




3 1761 11764896 4



Digitized by the Internet Archive
in 2022 with funding from
University of Toronto

<https://archive.org/details/31761117648964>



Department of Justice
Canada

Government
Publications

CA1 ①
J 800
- 83P106

WORKING PAPERS ON PORNOGRAPHY AND PROSTITUTION

Report # 6

CANADIANS' ATTITUDES TOWARD AND PERCEPTIONS OF PORNOGRAPHY AND PROSTITUTION

by
Peat Marwick & Partners

POLICY, PROGRAMS
AND RESEARCH BRANCH

RESEARCH AND
STATISTICS SECTION

Canada

A NATIONAL POPULATION STUDY
OF
PROSTITUTION AND PORNOGRAPHY

Peat, Marwick and Partners

October 22, 1984

This report was written under contract for the Department of Justice, Ottawa, Canada.
The views expressed in this report do not necessarily represent those of the Department.



EXECUTIVE SUMMARY

STUDY PURPOSE AND BACKGROUND

The purpose of this study, A National Study on Prostitution and Pornography, was to determine Canadian's attitudes toward and knowledge and perceptions of pornography and prostitution. Being the first large-scale study of its kind in Canada, the study was intended to serve several purposes:

- to determine public concepts toward pornographic material and prostitution activities. This involved an assessment of what the public considers to be offensive about prostitution and pornography, and perceptions about the harms (or benefits) of prostitution and pornography to themselves, their children and society, in general
- to develop a profile of the public regarding their usage of prostitution services and pornographic material
- to determine public awareness of pornography and prostitution in their communities, in other words, the degree of exposure to pornographic material or prostitution-related activities
- to identify the extent of public knowledge about existing legal controls dealing with pornography and prostitution
- to determine the extent of public satisfaction with existing controls covering pornography and prostitution and preferences for various policy options
- to determine the socio-demographic-economic and other factors which influence public concepts, usage, degree of exposure, legal knowledge and policy option preferences.



METHODOLOGY

The data-collection methodologies used in the survey were in-house personal interviews combined with a supplementary booklet. The in-house interviews were conducted as part of an omnibus survey. The supplementary booklet was left at the respondent's home and was picked up after a weeks' time had elapsed. Instruments were pre-tested in both official languages. The survey was then launched and interviews took place in the homes of respondents from June 18th to July 19th, 1984.

A national sample of 2018 men and women aged 18 and over were interviewed in their homes. The sample was made on scientific, probability techniques, allowing unbiased inferences to be drawn for Canada as a whole and for various domains within Canada.

As indicated above, a total of 2018 respondents completed the interview portion of the survey. Of these respondents, 1641 or 81% completed the supplementary booklet. This was a surprisingly high response rate, and indicated the level of interest of the public in these issue areas.

The analytical methodologies used in the survey were a combination of descriptive statistics and linear regression modelling.

SURVEY FINDINGS: PROSTITUTION ISSUES

Five issue areas were examined with respect to prostitution issues: public concepts, use, exposure, legal knowledge and policy options. The key survey findings are described below in relation to each of these areas and as well the influence of the explanatory variables (socio-demographic-economic and other factors) on them.



PUBLIC CONCEPTS

Public concepts were investigated in relation to respondents' definition of prostitution, their levels of acceptability towards prostitution and their beliefs about the issue. Exhibit E-1, overleaf, describes the survey findings related to the first two issue areas and Exhibit E-2, overleaf, describes the findings related to beliefs. Major highlights are presented below.

Definition of Prostitution

Within the framework of sexual bargaining, respondents were asked to indicate whether they believe the exchange of sex for money or for something other than money is prostitution. The findings reveal that:

- Although the vast majority of respondents consider the exchange of money for sex to be prostitution, there is a small group who do not.
- More respondents consider the exchange of money for sex to be prostitution than the exchange of a gift, dinner, etc.

Level of Acceptability

An examination of the level of acceptability associated with the sexual bargaining activities indicates that:

- More respondents find sexual bargaining activities unacceptable than acceptable.
- The exchange of sexual services for something other than money is slightly more acceptable than the exchange of sexual services for money (42% versus 35%).

In a separate investigation of the influence of scene and visibility on level of acceptability, responses indicate that:

EXHIBIT E-1

PUBLIC CONCEPTS TOWARD PROSTITUTION:

<u>DEFINITIONS OF PROSTITUTION</u>	<u>AGREE(%)</u>	<u>DISAGREE (%)</u>
Prostitution as sex in exchange for money	90	6
Prostitution as sex in exchange for something other than money	57	31
<u>LEVEL OF ACCEPTABILITY</u>	<u>ACCEPTABLE(%)</u>	<u>UNACCEPTABLE(%)</u>
Exchange of sexual services for money	35	62
Exchange of sexual services for something other than money	42	53

EXHIBIT E-2

PERCEPTIONS AND BELIEFS ABOUT PROSTITUTION

<u>Harms of Prostitution</u>	<u>Agree(%)</u>	<u>Disagree(%)</u>
Prostitution is linked to organized crime	60	11
Violence accompanies prostitution	59	16
Prostitution is a major cause of the spread of venereal disease	69	20
Prostitution has an effect on property values	62	16
Prostitution causes traffic congestion and noise	38	20
Street solicitation in areas where there are children is bad for children	84	6
<u>Attitudes Toward Clients and Prostitutes</u>		
Offended by solicitation by prostitute	52	42
Offended by men looking for prostitute	56	36
Prostitution is degrading to prostitute	51	18
Prostitution is degrading to customers	46	25
<u>Perceptions about the Economics of Prostitution</u>		
Juveniles resort to prostitution because of economic reasons	57	16
Women become prostitutes because of economic inequalities	43	26
Prostitutes make a lot of money	51	15
Prostitutes are controlled by pimps	60	8
<u>Inevitability of Prostitution</u>		
Prostitution will always exist no matter what is done	92	5



- There is less tolerance for public than for private displays of prostitution.
- There is some distinction between prostitution activities in different types of private places, with private commercial places being less acceptable than private apartments.
- The prostitution activity influences tolerance levels, with the viewing of prostitution-related activities such as bargaining or the actual sexual service much more offensive than the sight of prostitutes or street walkers.

Perceptions and Beliefs

The survey obtained respondents' beliefs about the harms of prostitution, their attitudes toward prostitutes and their clients, their perceptions about the economics of prostitution and its inevitability.

Harms of Prostitution

With respect to perceptions about the harms of prostitution, the prevalent thinking among respondents is that prostitution has harmful effects. The greatest degree of consensus is indicated with respect to the harmful effects of street solicitation on children in areas where there are children.

Attitudes Toward Clients and Prostitutes

Respondents' attitudes toward prostitutes and clients indicate that a double standard is not being applied. Exhibit E-2 shows that a substantial number of respondents regard customer-related activities with almost equal acceptability to that of prostitute-related activities. Respondents view prostitution similarly degrading to prostitutes as to clients, although more find it degrading to prostitutes. Further evidence that a double standard is not being



applied is found in respondents' views about who is responsible for acts of adult prostitution. They attributed these acts to customers and prostitutes in almost equal proportions (22% and 20%, respectively).

Economics of Prostitution

Most respondents (52%) attribute much of the cause for the occurrence of prostitution on economic reasons. This is supported by the large number of respondents who believe that juveniles resort to prostitution because they cannot find jobs and that women become prostitutes because of economic reasons. Not only do many respondents believe in the economic basis for turning to prostitution, but many also believe it is lucrative.

Inevitability of Prostitution

There is very strong agreement by respondents that prostitution will always exist no matter what is done.

USE PATTERNS

In order to determine the extent to which respondents participate in sexual bargaining activities, the survey examined whether they have previously paid or accepted money in exchange for sex. The survey found that:

- 96% of the respondents have never given money for sex. A total of 47 respondents or 4% of the males in the sample have done so one or more times.
- Less than 1% of the survey respondents have accepted money in exchange for sex.

EXPOSURE

Exposure was assessed in the survey by focussing on respondents' awareness of prostitution activities in their surroundings. The survey also investigated



exposure to prostitution activities which is gained through the experiences of others who have been involved in these activities. The survey findings of this issue area are described below:

- Awareness about solicitation activities is low, with most respondents indicating that they never observe such activities. Twelve percent of respondents see solicitation on their residential streets and 15% see this in the areas where they shop.
- Awareness about solicitation is greatest in specific provinces (Ontario and Quebec) and in larger cities.
- Fifteen percent of respondents know someone who has accepted money for sex and 21% know someone who has given money for sex. Thus, respondents are being exposed to prostitution activities more by their acquaintances (who have paid for sex) than by the actual visibility of solicitation.
- Respondents know someone who has participated in sexual bargaining activities in greater proportions than having done so themselves. Thus, respondents have been able to obtain information, share the experiences, etc. from someone involved in the exchange of sex for money yet much fewer actually partake in this activity.

LEGAL KNOWLEDGE

Exhibit E-3, overleaf shows the responses of questions dealing with respondents' awareness of the law surrounding prostitution. The first activity is legal and the fourth activity is legal under certain circumstances. The other four activities are illegal.

The findings indicate that respondents are least knowledgeable about the activities which are legal or legal under certain circumstances. Most respondents know that the other activities are illegal. As well, the findings show the respondents are overwhelmingly unanimous in their belief that activities related to prostitution and children are illegal.

EXHIBIT E-3

LEGAL KNOWLEDGE ABOUT PROSTITUTION

<u>ACTIVITY</u>	<u>LEGAL(%)</u>	<u>ILLEGAL(%)</u>
Buying an adult's sexual services in private	22	67
Adult selling his or her own sexual services in a brothel	8	84
Pressing or persistent solicitation for the purposes of prostitution	3	91
An adult buying the sexual services of children	1	97
An adult arranging for the prostitution of children	-	97
Arranging for the prostitution of other adults	4	90



One interpretation of these findings is that respondents have a good appreciation and knowledge of the legality or illegality of most these activities. However, it is more probable that respondents think all aspects of prostitution are illegal given that most declared all six activities were illegal and many could not distinguish the prostitution activity which is legal or the activity which is legal under certain circumstances.

PREFERENCES FOR POLICY OPTIONS

In relation to preferences for policy options, the survey investigated whether respondents believe that the current legal system deals adequately with prostitution. Although a great number of respondents feel the legal system is inadequate (64%), this does not necessarily imply a desire for more control or tougher measures. A further investigation of what respondents believe should be done about adult prostitution revealed that a substantial number of respondents suggest a legalization approach (32%). A somewhat larger proportion suggest more control and tougher laws (40%). A non-legal approach (social re-orientation, research) is suggested by 7% and another 9% suggest nothing should be done to deal with prostitution.

An examination was then made of what respondents feel should be done about prostitution and the extent to which police should have a role in its control. The survey findings to this issue area are described in Exhibit E-4, overleaf, and are highlighted below:

- In the realm of adult prostitution, respondents have a strong preference to prosecute the prostitute (62%). Only 17% of respondents feel that prostitutes should be left alone but that customers should be prosecuted, while many more, (50%) feel that prostitutes should be left alone but pimps should be prosecuted.
- A number of variations on a legalization approach for adult prostitution were examined. Sixty percent of respondents support a government role in the creation of zoning laws

EXHIBIT E-4

POLICY OPTIONS TO DEAL WITH PROSTITUTION

<u>Role of Government in Adult Prostitution</u>	<u>Yes(%)</u>	<u>No(%)</u>
Increase social service funds	59	33
Increase social services	57	36
Not do more than now	35	54
Create zoning laws to restrict prostitution activity	61	31
Leave prostitutes alone but prosecute customers	17	72
Leave prostitutes alone but prosecute pimps	50	41
Require prostitutes have licenses	63	28
Require prostitutes to have medical examinations	82	10
Make the law tougher against prostitutes	62	29
Decriminalize prostitution-related activities	40	47

Role of Government in Child Prostitution

Increase social service funds	86	12
Increase social services	79	15
Not do more than now	12	80
Tougher laws against the child prostitution pimps	93	2
Tougher laws against the customer	89	7
Tougher laws against the children	50	44

Acceptability of Prostitution Operations

Street solicitation for purposes of prostitution	11	84
Brothels	38	55
All forms of prostitution in designated areas of town	28	67
Prostitution on private premises	45	52
Escort and call-give services	43	52

Role of Police in Control of Prostitution

Increased power to control prostitution by police	71	6
---	----	---



and the requirement of licenses for prostitutes. Many respondents (82%) indicate the requirement for prostitutes to undergo medical examinations (which probably relates to the belief held by 69% of respondents that prostitution is a major cause in the spread of venereal disease).

- Another 40% specify that government should decriminalize adult prostitution; however, it was not possible to determine whether respondents could distinguish between the various legalization options and decriminalization.
- The need for tougher laws and increased social service efforts (or funds) is more widely supported for child prostitution than for adult prostitution.
- Tougher laws are more widely expressed for the adult prostitute than for the child prostitute, although both receive substantial support (62% and 50%, respectively).
- The more discrete forms of prostitution activities appear to elicit greater support from respondents than more openly visible types of prostitution, in accordance with an earlier finding which showed more visible prostitution activities are less acceptable to respondents.
- Substantial support for role of police in controlling prostitution is revealed -- 71% of respondents support increased power, 20% neither more nor less power and 6% support less power for police.

INFLUENCE OF THE EXPLANATORY VARIABLES ON PROSTITUTION ISSUES

The influence of the socio-demographic-economic and other explanatory variables on the prostitution issues is integrated in two models. The models are shown in Exhibits E-5 and E-6, overleaf, and depict the relationships influencing the two major prostitution control options -- legalization and more control. The major highlights are as follows:

Relationship of Preference for Legalization and Explanatory Variables

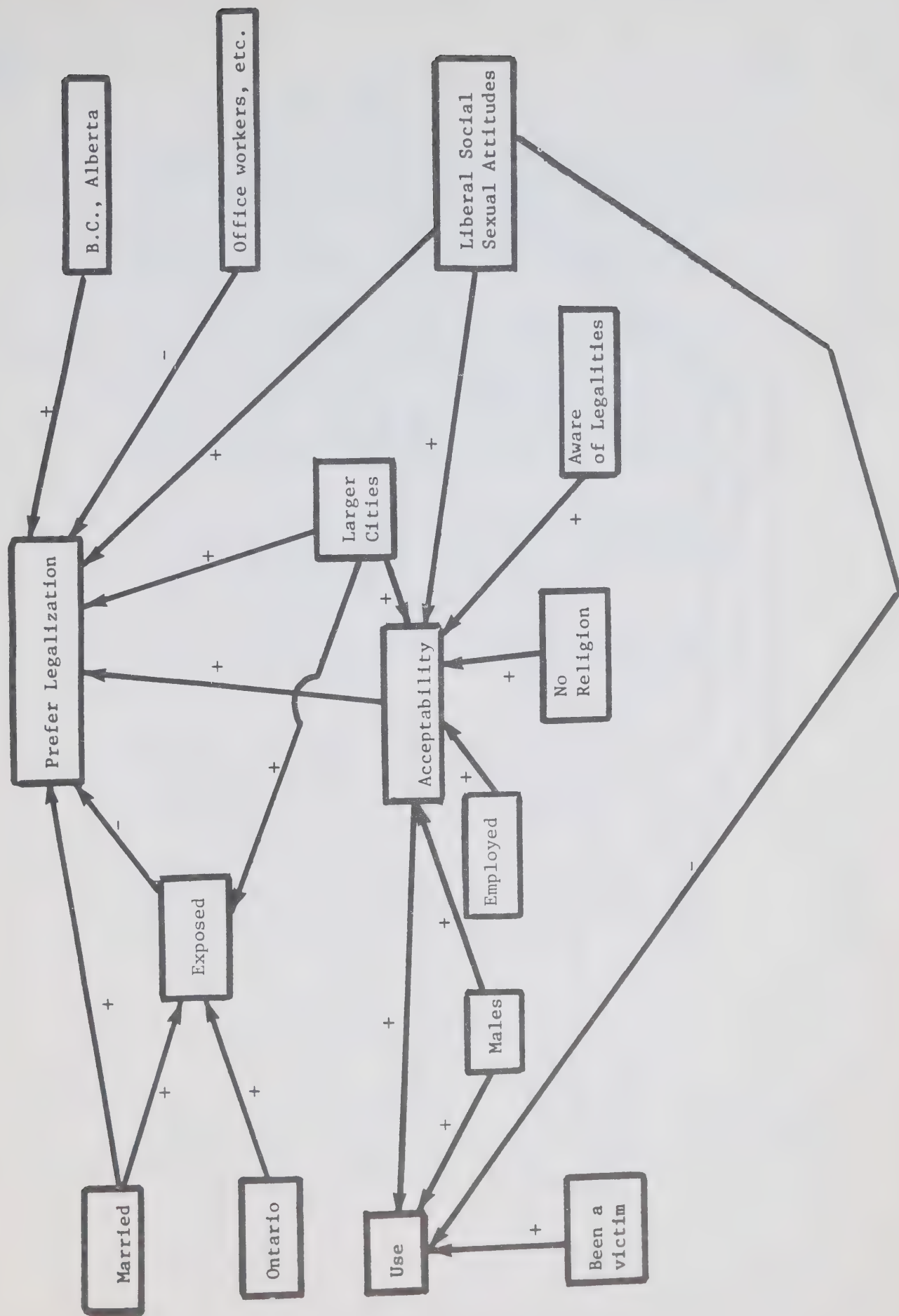
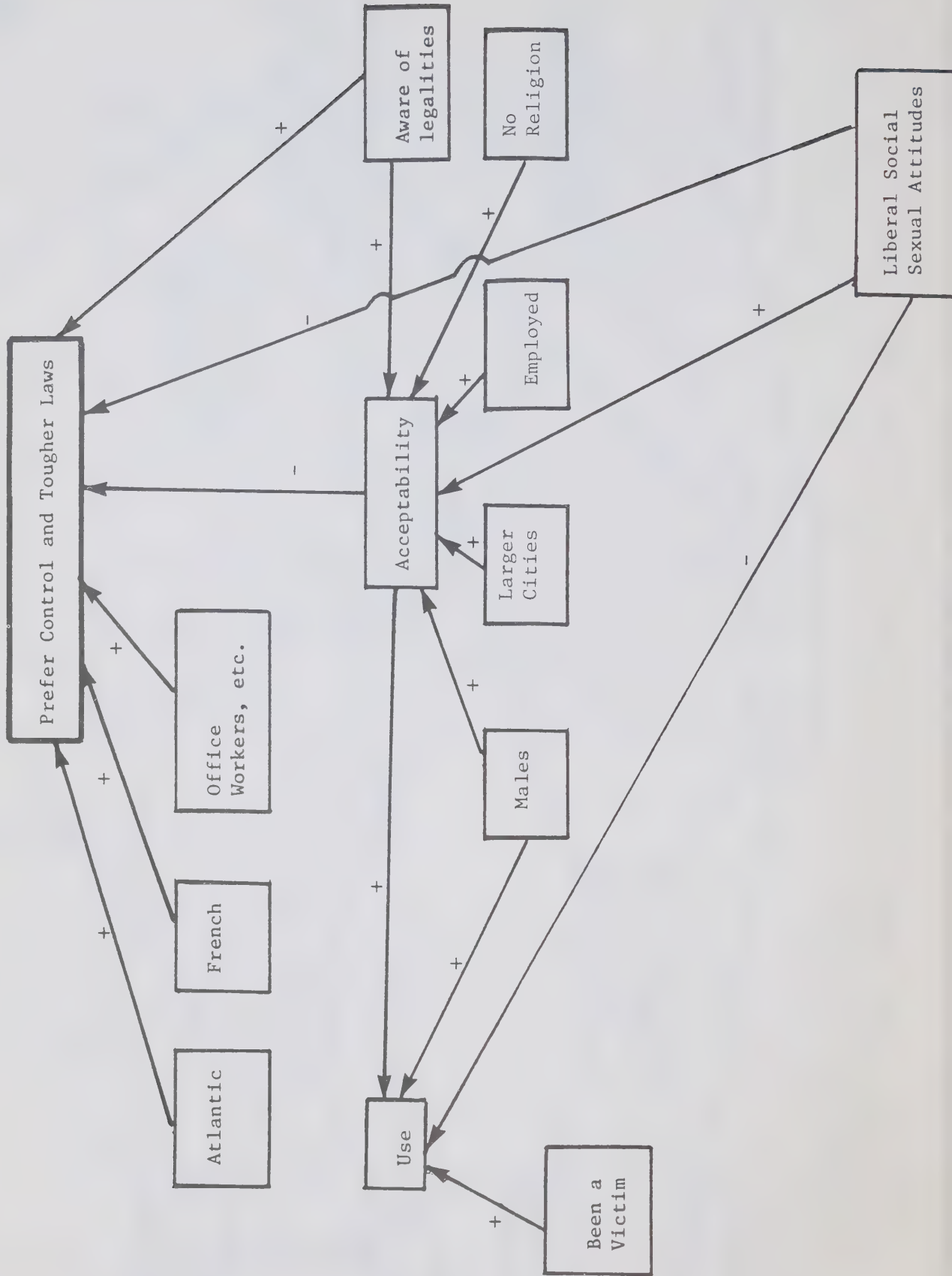


EXHIBIT E-6

Relationship of Preference for more Control and Explanatory Variables





- those preferring legalization are relatively more likely to be married, less exposed to solicitation, from larger cities, and with a relatively higher proportion in British Columbia and Alberta. They tend to be in occupations other than offices, sales, and service, have liberal social sexual attitudes, and tend to find prostitution acceptable
- those favouring more control and tougher laws are more likely to be French-speaking, from the Atlantic provinces, and in occupations like sales and services, or skilled, semi-skilled, and unskilled trades. They tend to find prostitution unacceptable, have conservative social sexual attitudes, and are more aware of the legalities related to prostitution
- those who have paid money in exchange for sex (users) are more likely to be males and also consider this activity more acceptable. Users have relatively more conservative social sexual attitudes and to have more likely been victims of sexual offenses
- individuals exposed to solicitation are more likely to be from larger cities, married, with a relatively high proportion in Ontario
- people who have wider levels of acceptability regarding prostitution are more likely to be males, from larger cities, employed, with no religious affiliation. They tend to be aware of the legalities of prostitution, and have more liberal social sexual attitudes
- it is also interesting to note that use does not affect preference for more control or legalization. Once attitudes on acceptability are controlled for, use has no significant explanatory power on policy options.

SURVEY FINDINGS: PORNOGRAPHY ISSUES

Five issue areas were examined with respect to pornography issues: public concepts, use, exposure, legal knowledge and policy options. The key survey findings are described below in relation to each of these areas and, as well,



the influence of the explanatory variables (e.g., socio-demographic-economic and other factors) on them.

PUBLIC CONCEPTS

Public concepts about pornography were investigated in relation to respondents' level of acceptability towards pornography. The influence of media, audience and scene on levels of acceptability were examined. As well, respondents were asked to express their views on pornography in general and their attitudes about the harms and benefits of pornography. The survey findings are described in turn.

Levels of Acceptability - Conjoint Analysis

The results of the conjoint analysis which measured the influence of scene, audience and media on acceptability levels are shown in Exhibit E-7, overleaf. The analysis shows that:

- Of the three audiences examined, there is little difference between viewing by oneself and viewing by other adults. There is a large difference between these two and an audience of children.
- Of the five scenes examined, sex combined with violence is the most unacceptable scene, followed by homosexual intercourse. These are more unacceptable than one or more nude men, and heterosexual intercourse. A scene with one or more nude women is the most acceptable of the five scenes.

EXHIBIT E-7

Influence of Scene, Audience and Media
on Level of Acceptability

<u>VARIABLE</u>	<u>INFLUENCE ON ACCEPTABILITY*</u>
SCENE	
- One or More Nude Women	1.34
- Two Adults of the Same Sex Engaged in Sexual Intercourse	.39
- Sex Combined with Violence	.00
- A Man and a Woman Engaged in Sexual Intercourse	.99
- One or More Nude Men	1.08
AUDIENCE	
- Viewing Myself	1.13
- Viewing by Other Adults	1.20
- Viewing by Children	.00
MEDIA	
- Entertainment Shows on T.V.	.05
- Entertainment Magazines	.01
- Entertainment Films	.00

* Higher values indicate higher acceptability



- There are not large differences among the three media. A given scene and audience for television seems to be somewhat more acceptable than the same scene and audience for magazines and films.
- An analysis of the relative contribution of the three variables, scene, audience, and media shows that audience (mainly explained by the children portion) is the most important explanation of acceptability, followed closely by scene. Media has little relative impact on acceptability.
- An analysis of acceptability levels resulting from combining scene, media and audience shows that the least acceptable situation is sex with violence, children as an audience and on film. The most acceptable situation is nude women, with other adults in the audience and on film.

Levels of Acceptability - General

Exhibit E-8, overleaf, shows the survey findings related to the investigation of level of acceptability toward pornography. Highlights are described below:

- In regard to the issue of pornography in general, the same number (approximately) of respondents feel pornography is acceptable as unacceptable.
- Many respondents have a fairly liberal opinion that individuals have the right to view sexually explicit material in private and to produce such material; however, they feel that individuals have a greater right to view sexually explicit material than producers have a right to produce sexually explicit material.

EXHIBIT E-8

Level of Acceptability
Towards Sexually Explicit Material

<u>Statement</u>	<u>Extent of Agreement</u>		
	<u>Agree(%)</u>	<u>Neither(%)</u>	<u>Disagree(%)</u>
All sexually explicit material for adult entertainment is obscene	31	23	42
Sex magazines are unacceptable in our society	45	18	35
Use of sexually explicit materials by adults is unacceptable	32	20	43
Everyone has the right to view sexually explicit material as long as it is done in private	66	15	16
Everyone has the right to produce sexually explicit materials so long as it does not hurt anyone	32	15	50



Perceptions and Beliefs Associated with Pornography

Exhibit E-9, overleaf, shows the survey findings related to the examination of perceptions and beliefs associated with pornography. Highlights are described below:

- Respondents reveal a strong belief that pornography is a problem in Canada. However, they do not feel it is as important as other social problems, since only 1% of respondents state pornography is a major social problem.
- The survey elicited the views of respondents regarding a number alleged harms and benefits of pornography. The prevalent thinking is that pornography does have harmful effects. The greatest degree of consensus is indicated with respect to the harmful effects of pornography on children and the unacceptability of material showing children.
- Some support is given to the beneficial or desirable aspects of pornography.

USE PATTERNS

Usage patterns were assessed by reviewing the type of media (magazines, television, videos) used, the material portrayed and the frequency of the materials' consumption. The survey findings of this issue area are described below:

- A large number of respondents (89%) report never having bought adult entertainment magazines in the last twelve months. Eighty-eight percent of respondents have not bought or rented adult-only video cassettes in the last twelve months. Fifty-seven percent of respondents have seen adult entertainment programs on T.V. showing nude adults in the last twelve months.
- Usage patterns for magazines are similar to those found for video cassettes.

EXHIBIT E-9

Perceptions and Beliefs Associated with Pornography

	<u>Agree(%)</u>	<u>Disagree(%)</u>
<u>Harm to Society-General</u>		
Pornography is a problem in Canada	59	26
<u>Harm to Society</u>		
Violent sexual material leads readers or viewers to commit acts of violence	69	17
Violent pornographic scenes are imitated by people in real life	48	24
<u>Degradation of Women</u>		
Sex magazines are degrading to women	67	21
Sex magazines are degrading to men	38	30
Women are portrayed in a more degrading fashion than men in sexually explicit material	66	15
<u>Harm to Children</u>		
Exposure to pornography cannot help children develop healthy sexual attitudes	76	9
Availability of sex magazines in areas frequented by children is bad for them	78	12
Sexually explicit material showing children is unacceptable in our society	94	4
<u>Benefits of Pornography</u>		
Sexually explicit material can be safe outlet for aggressive sexual behaviour	44	25
Sexually explicit material contributes to pleasurable sexual	32	30



- Television, more than magazines and video cassettes, is the medium where most respondents view adult entertainment magazines.
- Few respondents consume adult entertainment on all three media (6%). Most respondents view adult entertainment on television only (31%). A third of respondents never consume adult entertainment on any of the three media.

In an analysis of the type of material being viewed, the following patterns were found:

- Of the five scenes examined, the pattern of responses indicates that one or more nude women and a man and woman engaged in sexual intercourse are most frequently being viewed. This is followed in frequency by scenes showing one or more nude men, homosexual intercourse and sex combined with violence. The pattern relates directly to the level of acceptability (found in the conjoint analysis) held towards these scenes.

EXPOSURE

Exposure was assessed in the survey by focussing on respondents' awareness of adult entertainment material in their surroundings. They were also asked to indicate whether pornography was easily available and when they were first exposed to actual and pictorial nudity. The results of the survey questions dealing with exposure are described below:

- There is widespread awareness of the availability of a general type of adult entertainment near respondents homes (73%). They have much less knowledge of such material showing scenes with violence (43%) and even less knowledge of such material showing scenes with children (15%).



- Awareness about the availability of adult entertainment is less widespread in the Atlantic than in other provinces. The size of the community does not influence the extent of awareness about a general type of adult entertainment or that showing violence; however, awareness about material showing scenes with children is higher in larger communities.
- Most respondents (74%) consider pornography to be easily available to everyone. A substantial number of respondents believe that pornography is easily seen on television (48%).
- The survey findings indicate that respondents are being exposed to some form of material showing nudity and to actual nudity at a fairly young age (by the time they are 15 years old). As well, respondents are being exposed to pictorial nudity at an earlier age than to actual nudity.

LEGAL KNOWLEDGE

Respondents' awareness of the legalities surrounding sexually explicit material was examined by asking them to indicate whether sexually explicit material which offends their local community standards and material showing scenes of violence, horror or cruelty are legal.

The survey findings revealed that:

- 32% of respondents correctly indicate that sexually explicit material which offends local community standards is legal. Fifty-one indicate it is illegal
- 62% of respondents correctly indicate that material showing scenes of violence, horror or cruelty is illegal. Twenty-seven percent indicate it is legal.



Although a number of respondents do have a knowledge of the facts, there are a substantial number who do not know the legalities surrounding pornographic material, particularly in regard to the local standards situation. The pattern which emerges is that respondents generally think activities related to sexually explicit material are illegal, given a substantial number of respondents indicate this for the two situations considered in the survey.

POLICY OPTIONS

The views of respondents were obtained regarding who they believe should take the lead role in the control of sexually explicit material and whether police and censor boards should have more power to control this material.

The following highlights the results of this line of investigation:

- A government role in the control of sexually explicit material is favoured by most respondents (59%). A smaller number of respondents favour personal and family discretion in the control of this material (16%).
- A substantial number of respondents feel police and censor boards should have more power to control sexually explicit material (67% and 66%, respectively).

Respondents were also asked to express their views on what should be done about particular sexually explicit scenes found in various media or locations. The findings indicate that:

- Banning the material is mainly felt to be required for scenes showing violence or scenes showing sexual intercourse between adults of the same sex. The media in which these scenes are shown does not influence the action chosen.



- Forbidding the material to be presented or sold to children is most favoured for magazines showing nude men or women which are sold in a local newstand and for entertainment programs showing nude adults when children might be watching. Banning is also strongly favoured for all these materials.
- Family or personal discretion, combined with a forewarning that the material may be offensive, is most favoured for late-night television showing heterosexual intercourse, nude adults in entertainment movies and sexually explicit paintings in an art gallery.
- Fining or jailing the producers is the least preferred measure.
- The least repressive measures (e.g., family discretion) are suggested for sexually explicit material in an art gallery.

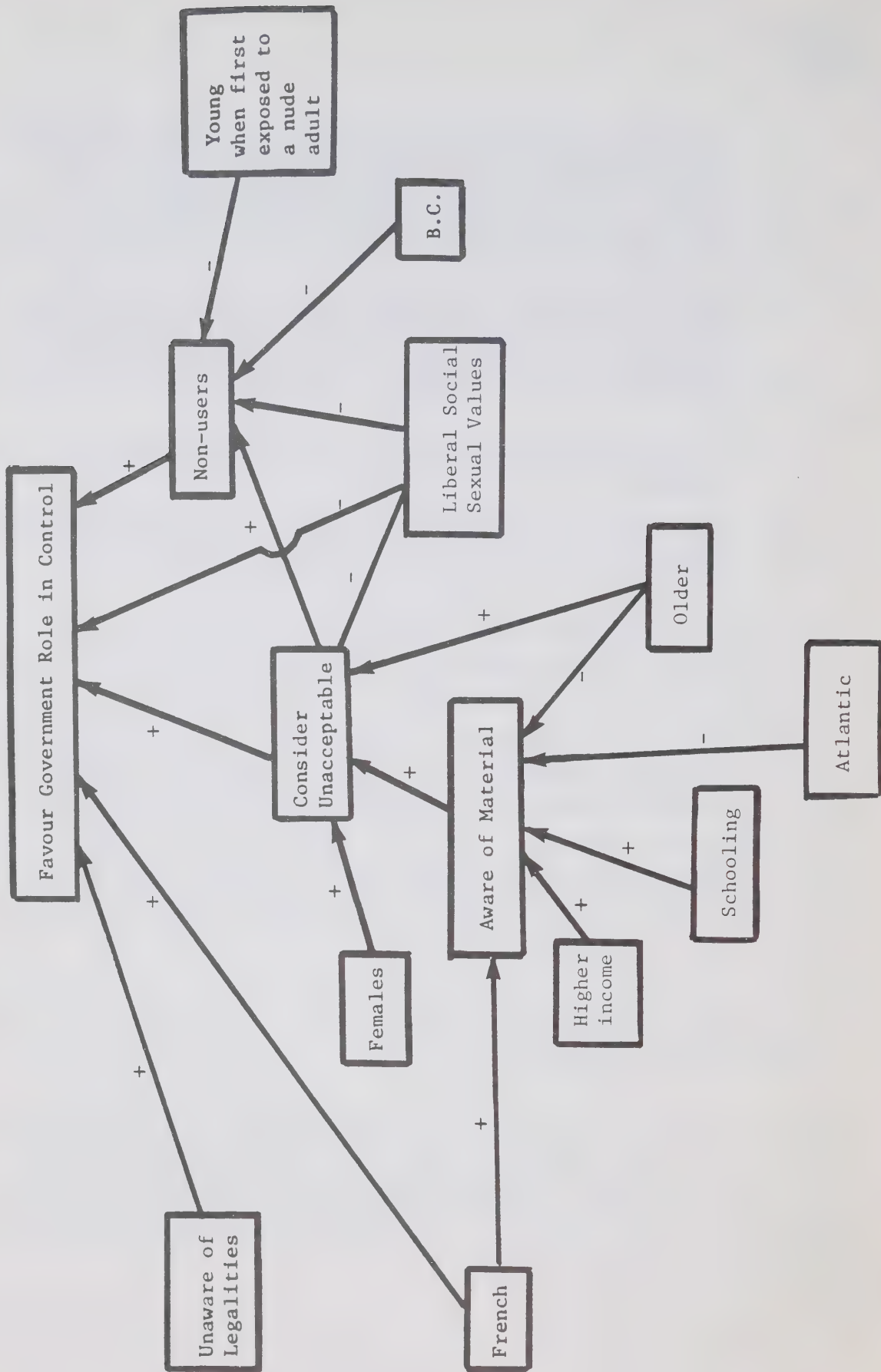
It appears that respondents are not influenced by the media when choosing a specific measure; however, they are influenced by the scene and audience. The potential for children as an audience evokes strong control measures. As well, stronger measures are favoured for scenes which are less acceptable (as determined by the conjoint analysis) to respondents. The artistic/educational value of the material is also a consideration influencing preferences for control measures; however, it is not as important as the scene and audience. Finally, respondents appear to favour control actions over material which is already available in the marketplace rather than to deal with the source of the material, i.e., deal with the producers.

INFLUENCE OF THE EXPLANATORY VARIABLES ON PORNOGRAPHY ISSUES

The influence of the socio-demographic-economic and other explanatory variables on the pornography issues is integrated in a model shown in Exhibit E-10, overleaf. The model integrates the relationships influencing the major pornography policy option, the requirement for a government role in the control over sexually explicit material.

EXHIBIT E-10

Relationship of Preferences for a Government Role and Explanatory Variables





The major highlights are as follows:

- those unaware of the legalities regarding pornography, non-users, those with conservative social sexual values, those who consider adult entertainment material unacceptable, and those speaking French are relatively more likely to favour government control
- use of adult entertainment material is directly influenced by age of first exposure to a nude adult, social sexual attitudes, and acceptability. Those living in British Columbia also have a relatively higher level of use
- acceptability is influenced by social sexual attitudes and awareness. Older people and females consider adult material relatively less acceptable
- awareness of sexually explicit materials is higher among the younger, higher income, more educated, French-speaking people and those outside the Atlantic provinces.

COMPARISON OF PROSTITUTION AND PORNOGRAPHY ISSUES

As part of the survey analysis, a comparison of respondents' views and attitudes toward pornography and prostitution was undertaken. The key findings are described below, in relation to the five key issues areas: public concepts, use, exposure, legal knowledge and policy options.

PUBLIC CONCEPTS TOWARD PROSTITUTION AND PORNOGRAPHY

Public concepts were examined by reviewing levels of acceptability toward prostitution and pornography and perceptions about their harms. In regard to the level of acceptability held toward the two issues:



- A comparison of the aggregate results indicates that the acceptability of the sexual bargaining activities and of sexually explicit material (in general) is quite similar. When the sexually explicit material is defined in the context of a specific scene or audience, a large gap emerges between the two issues. The sexual-bargaining activities are more acceptable to the respondents than material showing homosexual intercourse or violent sexual scenes and material which is accessible to children. This is consistent with the results of our conjoint analysis, where these scenes and an audience with children were found to be less acceptable.

In relation to public perceptions about the harms of pornography and prostitution:

- The prevalent thinking among respondents is that prostitution and pornography have harmful effects.
- The most concern is revealed in regard to the harmful effects on children with respect to both issues.

USE: EXCHANGE OF MONEY FOR SEX AND
CONSUMPTION OF ADULT ENTERTAINMENT

A comparison of prostitution and pornography usage patterns reveals that:

- Consumption of adult entertainment material is much more frequent than is the payment of money in exchange for sexual services. Even the proportion of respondents who consume adult entertainment on all three media (6%) exceeds the proportion who have paid for sexual services.
- Respondents who consume adult entertainment material tend to give money in exchange for sex relatively more often than those who never consume this material. The converse is also true. Respondents who have paid for sexual services tend to consume relatively more sexually explicit material than those who have not paid for sexual services. Most respondents have consumed adult entertainment (on television) and have never paid money for sex (54%).



EXPOSURE TO PROSTITUTION AND PORNOGRAPHY

A comparison of awareness about solicitation and adult entertainment shows that:

- There appears to be much more widespread awareness of the availability of adult entertainment than about solicitation activities.
- Because awareness of adult entertainment material is so much more widespread compared to solicitation, it is not surprising that most respondents (54%) tend to be aware of adult entertainment but not of solicitation near their homes. Only 10% are aware of both adult entertainment and solicitation and a similar proportion are unaware of both of these near their homes.
- Awareness of solicitation and adult entertainment appears to be higher in specific provinces. Ontario residents tend to have the highest awareness about solicitation in residential areas. Awareness of adult entertainment is lowest in the Atlantic.
- Awareness of adult entertainment material implies awareness of solicitation. The reverse is also true; respondents who are aware of solicitation near their homes are more inclined to see adult entertainment in their residential neighbourhood.
- Provinces where there is the most awareness of solicitation activities are not necessarily the same as the provinces where the awareness of sexually explicit material is the highest. The exceptions are Ontario and Quebec, where awareness is relatively high for both solicitation and adult entertainment material.
- Awareness of solicitation is more frequent in larger cities, while awareness of sexually explicit material is fairly similar across different size communities.



LEGAL KNOWLEDGE ABOUT PROSTITUTION AND PORNOGRAPHY

A comparison of the respondents' awareness of the legalities surrounding prostitution-related activities and sexually explicit material indicates that:

- Overall, there is not a great deal of knowledge of the laws surrounding prostitution and pornography. Most respondents believe that the activities surrounding these issues are illegal.
- Few respondents are knowledgeable of both issues.
- There does not appear to be a clear relation between the respondents' knowledge about the legalities of prostitution and their knowledge about the legalities of pornography, i.e., knowledge about one issue does not necessarily imply knowledge about the other issue.

POLICY OPTIONS TO DEAL WITH PROSTITUTION AND PORNOGRAPHY

A comparison of the policy options to be taken to deal with prostitution and pornography indicates that:

- Some type of government role is preferred by a substantial number of respondents to deal with prostitution and sexually explicit material.
- Most respondents (50%) who favour an outside role (some control) over sexually explicit material, also desire this for prostitution (more control and legalization).
- The requirement for more police power to control prostitution and sexually explicit material is favoured by many (71% and 66%, respectively).
- A substantial number of respondents (73%) indicate the same preferences for police control over both issues and only 4% indicate preferences which differ distinctly. A total of 59% of respondents indicate the requirement for more control by police to deal with prostitution and pornography.



- There is quite a high level of consensus regarding the need to take strict actions with respect to child prostitution and sexually explicit material which is accessible to children.
- Most respondents who favour an increased role for government in dealing with child prostitution also favour strong actions to protect children from sexually explicit material.



A NATIONAL POPULATION STUDY OF
PROSTITUTION AND PORNOGRAPHY

TABLE OF CONTENTS

	<u>Page</u>
I INTRODUCTION	I.1
Study Purpose and Background.	I.1
Methodology	I.2
Analytical Methodology	I.4
Report Organization	I.7
II PROSTITUTION ISSUES	II.1
Public Concepts About Prostitution.	II.1
Definition of Prostitution	II.1
Level of Acceptability	II.4
Public Perceptions About Prostitution.	II.11
Use Patterns.	II.23
Frequency of Giving Money in Exchange for Sex	II.23
Frequency of Accepting Money for Sex	II.23
Degree of Exposure to Prostitution - Related Activities	II.25
Exposure to Solicitation	II.25
Exposure through Experience of Others.	II.28
Legal Knowledge About Prostitution - Related Activities	II.30
Preferences for Policy Options.	II.32
Adequacy of Current Legal System	II.33
Options to Deal with Prostitution.	II.35
Role of Government in Dealing with	
Adult Prostitution.	II.39
Role of Local Police	II.41
Attitudes Toward Various Prostitution	
Operations.	II.41
Role of Government in Dealing with	
Child Prostitution.	II.42
Summary of Survey Findings Regarding	
Prostitution Issues	II.43



A NATIONAL POPULATION STUDY OF
PROSTITUTION AND PORNOGRAPHY

TABLE OF CONTENTS (Cont')

	<u>Page</u>
III PORNOGRAPHY ISSUES	III.1
Public Concepts About Pornography	III.1
Levels of Acceptability: General.	III.2
Level of Acceptability by Scene, Audience and Media (Conjoint Analysis).	III.4
Level of Acceptability and Proximity	III.8
Perceptions and Beliefs Associated with Pornography	III.9
Use Patterns: Adult Entertainment.	III.15
Magazines	III.15
Video Cassettes.	III.17
Television Shows	III.18
Type of Material Used by Media: A Comparison	III.20
Use of Adult Entertainment: Magazines, Videos and/or Television	III.21
Degree of Exposure to Sexually Explicit Material.	III.22
Awareness of Sexually Explicit Material Near One's Home	III.22
Availability of Pornography.	III.25
Age of First Exposure.	III.25
Legal Knowledge About Sexually Explicit Material.	III.26
Policy Options: Control of Sexually Explicit Material	III.27
Lead Role in the Control of Sexually Explicit Material	III.28
Role of Police and Censor Boards	III.30
Policy Options - Media and Scene Specific.	III.34
Summary of Survey Findings Regarding Pornography Issues	III.38



A NATIONAL POPULATION STUDY OF
PROSTITUTION AND PORNOGRAPHY

TABLE OF CONTENTS (Cont'd)

	<u>Page</u>
IV A COMPARISON OF PROSTITUTION AND PORNOGRAPHY ISSUES.	IV.1
Public Concepts Toward Prostitution and Pornography	IV.2
Use: Exchange of Money for Sex and Consumption of Adult Entertainment	IV.6
Exposure to Prostitution and Adult Entertainment	IV.9
Legal Knowledge About Prostitution and Pornography.	IV.11
Policy Options to Deal with Prostitution and Pornography	IV.13
Summary: Comparison of Prostitution and Pornography Issues	IV.17

APPENDICES

- A - Survey Instruments
- B - Description of the Sample Population
- C - Classification of Questions by Issue Area
- D - Dummy Variables Used in Regression Analyses
- E - Design for Regression Analyses
- F - Survey Results Not Incorporated into Main Report
- G - Future Areas of Research

EXHIBITS

1. Effect of Socio-Demographic-Economic Variables on the Acceptability of Sexually Explicit Material with Children.



A NATIONAL POPULATION STUDY OF
PROSTITUTION AND PORNOGRAPHY

TABLE OF CONTENTS (Cont'd)

EXHIBITS (Cont'd)

2. Definition of Prostitution.
3. Definition of Prostitution and Explanatory Variables.
4. Effect of Socio-Demographic-Economic Variables on the Acceptability of Sex in Exchange for Money.
5. Relationship of Acceptability and Definition.
6. Acceptability of Sexual Bargaining Activities and Explanatory Variables.
7. Acceptability of Sexual Bargaining Activities, Exposure and Social Sexual Attitudes.
8. Level of Acceptability by Scene and Location (Visibility).
9. Relationship of Socio-Demographic-Economic Variables on Views Regarding the Effects of Prostitution.
10. Absolute Frequency of Giving and Accepting Money for Sex.
11. Exchange of Money for Sex and Explanatory Variables.
12. Exchange of Money for Sexual Services, Exposure and Public Concepts.
13. Frequency of Visibility of Solicitation for the Purposes of Prostitution in Respondents' Neighbourhood by Province and Selected Major Centres.
14. Effect of Socio-Demographic-Economic Variables on Knowing Someone Who has Given Money in Exchange for Sex.
15. Relationship of Socio-Demographic-Economic Variables on Legal Knowledge.



I - INTRODUCTION

STUDY PURPOSE AND BACKGROUND

The purpose of this study, A National Population Study on Prostitution and Pornography, was to determine Canadians' attitudes toward and knowledge and perceptions of prostitution and pornography. Being the first large-scale study of its kind in Canada, this study was intended to serve several goals:

- to determine public concepts toward pornographic material and prostitution activities. This involved an assessment of what the public considers to be offensive about prostitution and pornography, and perceptions about the harms (or benefits) of prostitution and pornography to themselves, their children and society, in general
- to develop a profile of the public regarding their usage of prostitution services and pornographic material
- to determine public awareness of pornography and prostitution in their communities, in other words, the degree of exposure to pornographic material or prostitution-related activities
- to identify the extent of public knowledge about existing legal controls dealing with pornography and prostitution
- to determine the extent of public satisfaction with existing controls covering pornography and prostitution and preferences for various policy options
- to determine the socio-demographic-economic and other factors which influence public concepts, usage, degree of exposure, legal knowledge and policy option preferences.



This national adult population survey is only one of several studies on pornography and prostitution issues which is being undertaken by the Department of Justice.* In combination, these studies are expected to provide meaningful information upon which appropriate policy decisions on these two important issues will be based.

METHODOLOGY

Overall Approach

The data-collection methodologies used in the survey were in-house personal interviews combined with a supplementary booklet. The in-house interviews were conducted as part of an omnibus survey.** At the time of the in-house interview, the interviewer left a supplementary booklet which the respondent was asked to complete within a week. The supplementary booklet was then picked up by the interviewer after a week's time had elapsed.

* Some of the other studies include: field surveys of prostitutes and customers in B.C., the Prairies, the Maritimes, Ontario and Quebec; a survey of producers and distributors in Toronto and Montreal; a study of the way both issues have been handled by the press; two independent content analyses of pornographic films and videos; and a study of several provincial censor boards.

** The omnibus survey deals with the opinions, attitudes and behaviour of Canadians toward various social, economic, political and cultural phenomena. It is conducted five times a year. The main reason for using the omnibus survey approach, as opposed to an in-house survey only on prostitution and pornography, was that the response rates for the omnibus were expected to be much greater. This is primarily due to the fact that the research questions on prostitution and pornography were added to a list of questions drawn from other topical areas (e.g., electoral opinions, buying habits, etc). Thus, although the respondent was asked sensitive questions on prostitution and pornography, these arose at the end of the interview -- after the interviewer had time to establish rapport with the respondent.



Questionnaire Development and Pre-testing

The questions which were incorporated into the omnibus survey and the booklet were developed in consideration of the informational needs of the Department surrounding the issues of prostitution and pornography. Prior to the design of the draft questionnaire, a complete analytic framework was prepared. The draft survey instruments were prepared in both official languages and pre-tested. Following the pre-test, the instruments were revised. The survey was then launched and interviews took place in the homes of respondents from June 18th to July 9th, 1984. Appendix A contains the omnibus survey and supplementary booklet.

Sampling Design and Validity

A national sample of 2,018 men and women aged 18 and over were interviewed in their homes. The sample was based on scientific, probability techniques, allowing unbiased inferences to be drawn for Canada as a whole and for various domains within Canada.

The sampling technique consisted of five major selection steps (stratification by geographic region, stratification by community size, selection of interviewing locations, selection of census tracts and selection of blocks). The selection of households took place starting with a specified household within the block. Strict quotas were imposed concerning age group, sex and women working outside the home in order to ensure proportional representation of each group in the sample.

The stratification of the sample was done by six regions and four community sizes in order to enhance the accuracy of the results for key sub-groups, such as smaller regions and francophones. The data for each region and community size stratum were weighted to yield unbiased results.

Ten percent of the interviewers' work was validated by field supervisors to ensure that interviews were conducted courteously, accurately, and comprehensively.



Respondent Response

As indicated above, 2,018 respondents completed the omnibus portion of the survey. Of these respondents, 1,641 or 81% completed the supplementary booklet. This was a surprisingly high response rate, and indicated the level of interest of the public in these issue areas.

Both the omnibus and booklet populations have very similar socio-demographic-economic characteristics to the census population. A full description of the omnibus and booklet sample is provided in Appendix B.

ANALYTICAL METHODOLOGY

Models

All models used in this analysis were of a linear regression format. For variables of interest, we generally created two models - one with only the socio-demographic-economic variables,* and one with both socio-demographic-economic variables and other explanatory variables** (use, exposure, attitudes, etc.). The models were constructed as a series of iterations between logical thinking and various kinds of explanatory analytic techniques. In no case did we begin with a pre-determined model specification, and merely estimate model values. In other words, model identification and estimation were both required in every case. Significance levels should be interpreted with this in mind.

* Most of socio-demographic-economic breakdowns require no explanation. Income is the annual income of all family members living in the same household. Geographic areas are established by provincial boundaries. Community size is defined by stratum-according to city size: 1,000,000 inhabitants or more; 100,000 to 999,999 inhabitants; 5,000 to 99,999 inhabitants and under 5,000 inhabitants. Language is that used most frequently at home. Respondents' occupations were categorized into five major groupings: professional, administrator and big business owner; technical, semi-professional and small business owner; clerical, sales and service; skilled, semi-skilled and unskilled laborers; and homemakers.

** An explanation of how questions were organized into specific variables is included in Appendix C. Appendix D describes the variables used in the regression models and Appendix E includes the analytical framework.



Significance Levels

All significance levels in the report are based on the regression models. In discussing the influence of socio-demographic-economic models, it is only the model with these variables which is used in the significance testing. For discussing the influence of other variables, the complete model is used in the estimation of significance levels.

The implication of this is that a relationship between two variables may be very strong, but if we feel that it is explained by other variables, it will then not be reported as significant. To illustrate this, consider the example discussed below.

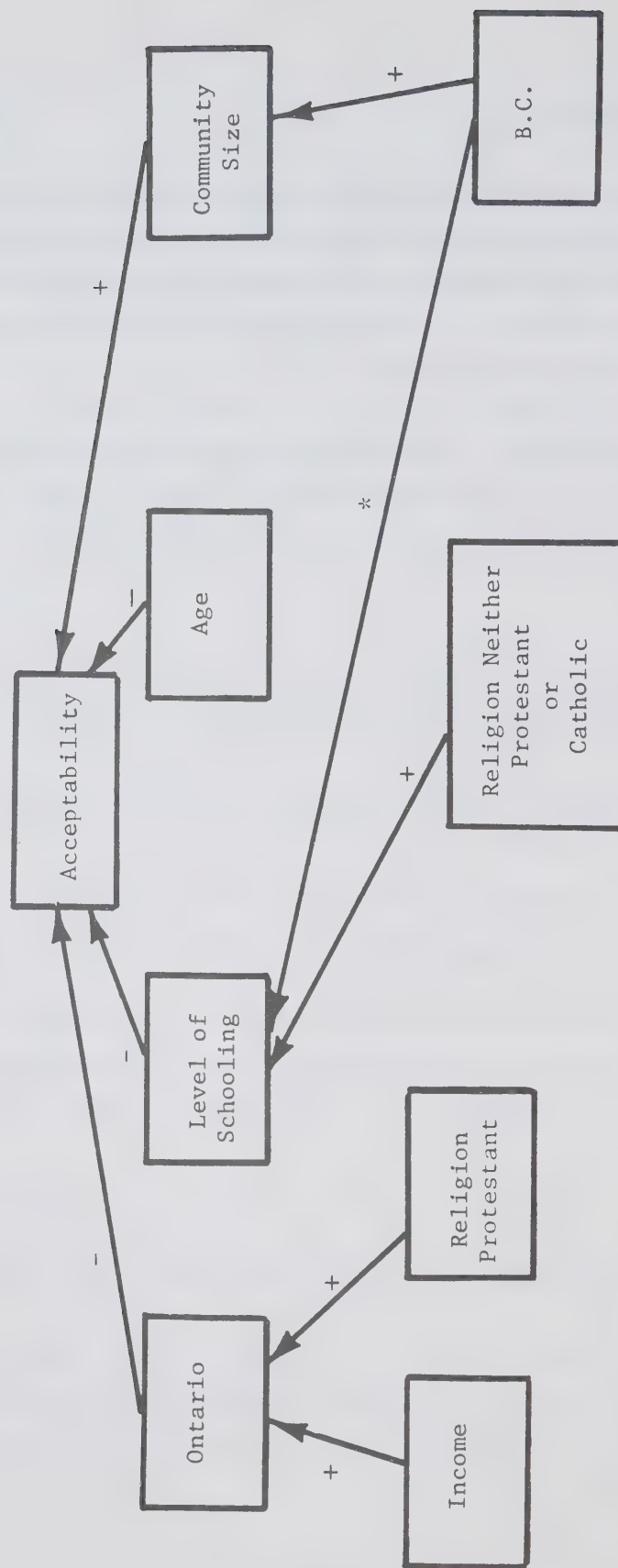
We analyzed the answers to the question on how acceptable is sexually explicit material showing children. Initial descriptive analysis showed:

- higher-income respondents found it relatively less acceptable
- individuals in Ontario, less acceptable
- older people, less acceptable
- less educated individuals, more acceptable
- people in larger communities, more acceptable
- Protestants, more acceptable
- individuals neither Catholic and Protestants, more acceptable
- individuals in British Columbia, more acceptable.

Each of these relationships, on their own, is statistically significant. However, in analyzing their interrelationships, we came up with the picture shown in Exhibit 1, overleaf. Analyzing this Exhibit, we see the following:

EXHIBIT 1

EFFECT OF SOCIO-DEMOGRAPHIC - ECONOMIC INFLUENCES ON THE ACCEPTABILITY OF SEXUALLY EXPLICIT MATERIAL WITH CHILDREN



* No sign has been assigned because individuals with less than eight years of scheduling and more than 14 years of schooling find the material less acceptable than individuals with schooling in the middle group (i.e., 8-13 years of schooling). Thus a direct linear relationship does not exist between acceptability and schooling.



- the effect of income seems mainly due to the Ontario effect, i.e., Ontario has a relatively high proportion of higher-income people. When province is controlled for, income is not important. In other words, individuals in the same province but with different incomes do not differ significantly in their feelings about the acceptability of sexually explicit material with children
- similarly, the Protestant religion effect disappears when province (Ontario) is controlled for
- individuals neither Protestant nor Catholic are relatively better educated. When education is controlled for, this religion effect disappears
- individuals in British Columbia have a relatively high proportion in the grade 9-13 school level and are represented in relatively larger communities. When schooling and community size are taken into account, there is no difference in acceptability between British Columbia residents and others (except, of course, for those in Ontario).

Thus in reporting on differences in responses to the acceptability of sexually explicit material with children, only Ontario, level of education, age and community size are reported as significant.

Significance levels are reported in the p notation. For example, $p = .0324$ implies a level of significance of .0324, i.e., we are 96.76% confident that the observed differences was not due to chance.* We normally used a cut-off point for significance of $p = .1000$. If effects seemed interesting at higher levels, they were always reported with their specific significance levels mentioned. In the reporting of regression models, t -values were also described to illustrate the strength of relationships. The absolute value of the t -score, like the significance level, indicates the strength of the

* Bear in mind earlier statements about model-building, i.e., that we used the data to specify as well as estimate the models. Some split-sample validations were done, and showed the models to be relatively robust.



relationship. A t-score of 14 indicates a stronger relationship than one of 9, even though both have significance levels of .0000.

Missing Data

There is no definitive way of handling missing data items. We felt that our missing data items were rare enough to allow valid modelling even if entire records were deleted that contained relevant missing data items. Thus for our final model, listwise deletion was used, i.e., an individual was eliminated from the model if he had missing data on any of the variables used in the final model. Results were not very different from the models examined by mean substitution (replacing the missing item by the average over all respondents on that variable). Missing values are shown, as appropriate, in the descriptive statistics.

Percentages Not Totaling 100%

The computer rounds off each percentage to the nearest whole percent. As a result the percentages in an exhibit frequently add up to 99 or 101 rather than 100.

REPORT ORGANIZATION

The main body of the report is organized as follows:

- Chapter II deals with prostitution issues and examines five major areas -- public concepts and perceptions about prostitution, usage of prostitution services, degree of exposure to prostitution activities, legal knowledge about prostitution and preferences for policy options to deal with prostitution
- Chapter III deals with pornography issues and is organized the same way as the previous chapter
- Chapter IV compares the prostitution and pornography issues simultaneously.



There are also seven appendices. Appendix A includes the survey instruments. A full description of the sample population is provided in Appendix B. An explanation of how questions were organized into specific variable categories is included in Appendix C. Appendix D describes the variables used in the regression models and Appendix E includes the analytical framework. Appendix F elaborates the results of survey questions not incorporated in the main report. Finally, Appendix G includes a discussion of some areas of future research.



II - PROSTITUTION ISSUES

This chapter considers five areas related to prostitution. Public concepts and perceptions about prostitution are discussed first. This is followed by an elaboration of survey findings on use, exposure, legal knowledge and policy options. A final section provides a summary of the findings.

PUBLIC CONCEPTS ABOUT PROSTITUTION

The survey examined three key areas which deal with public concepts about prostitution:

- The first area dealt with the public's definition of prostitution. Values such as explicit bargaining of sex for money versus sex in exchange for other goods and services were itemized and the respondent was asked "to draw the line" between what he/she considered to be prostitution and non-prostitution activities.
- The second area probed public standards of acceptability/offensiveness related to prostitution activities. The levels of acceptability/offensiveness were elicited from the perspective of the respondents in relation to monetary and non-monetary sexual bargaining. The level of acceptability associated with particular prostitution-related activities was also examined.
- The third area investigated public perceptions and beliefs associated with the reasons for the existence of prostitution and the effects (both to society as a whole and to participants and customers) of prostitution activities. Public attitudes toward the participants of prostitution activities were also examined.

Each key area is described below.

DEFINITION OF PROSTITUTION

Prostitution is usually defined in the context of general sexual bargaining. Within this framework, survey respondents were asked to indicate whether they considered the exchange of sexual services for money and the exchange of sexual services for something other than money to be prostitution.



Exhibit 2a, overleaf, depicts the survey responses to the questions:

- would you say that sex between two adults in exchange for money is prostitution?
- would you say sex between two adults which is exchanged for something other than money, such as dinner, a gift, or a vacation, is prostitution?

The findings indicate that more respondents consider the exchange of money for sex to be prostitution as opposed to the exchange of a gift, dinner, etc. A substantial number of respondents, however, do define sexual services in exchange for something other than money as prostitution. Ninety percent of respondents indicate that sex in exchange for money is prostitution. Fifty-seven percent of respondents indicate that sex in exchange for something other than money is prostitution.

Exhibit 2b, overleaf, compares respondents' responses to the two definitions of prostitution. The Exhibit shows that 56% of respondents consider both sexual bargaining definitions to be prostitution. Only 5% do not consider either the monetary or non-monetary exchange for sexual services definitions to be prostitution. Twenty-eight percent of respondents that do consider sex in exchange for money to be prostitution, do not consider sex in exchange for something else to be prostitution.

In order to understand influences or differences (as a result of socio-demographic-economic variables) in responses to these questions a regression model was built. The model shows that there are significant links with occupational group, geographic area of residence and marital status for the question of whether sex in exchange for money is prostitution:

- respondents in the skilled, semi-skilled and unskilled occupational group, more than any other occupational group, feel that the monetary exchange for sex is not prostitution (p = .0082). This occupational group has

Exhibit 2

Definition of Prostitution

(a) Sexual Bargaining Definitions of Prostitution

	<u>Would you say sex between two adults in exchange for money is prostitution?</u>	<u>Would you say that sex between two adults which is exchanged for something other than money is prostitution?</u>
Yes	90%	57%
No	6	31
It depends	3	9
Don't know/ No answer	<u>2</u>	<u>3</u>
Total	100%	100%

(b) Comparison of Definitions of Prostitution

		<u>Yes</u>	<u>No</u>	<u>Missing</u>	<u>Total</u>
Sex between two adults in exchange for something other than money	Yes	1129*	17	10	1156
		62%**	13%	13%	-
		56%***	1%	0%	57%
	No	500	102	34	636
		28%	78%	45%	-
		25%	5%	2%	32%
	Missing	183	11	32	226
		10%	8%	42%	-
		9%	1%	2%	12%
	Total	<u>1812</u>	<u>130</u>	<u>76</u>	<u>2018</u>
		100%	100%	100%	100%
		90%	6%	4%	100%

* Count

** Column %

*** Total %



relatively more males than females. Nine percent of respondents in this group indicate that they do not think sex in exchange for money is prostitution whereas 5% to 6% indicate the same response in the other occupational groups

- Atlantic residents more than residents of the other provinces define sex in exchange for money as prostitution ($p = .0407$). Ninety-four percent of these respondents answered affirmatively to this definition, while those in other provinces responded with less agreement (e.g., 89% in Ontario and B.C.)
- everything else being equal, married people are more likely to agree with the monetary exchange for sex definition of prostitution ($p = .0911$).*

The model shows that there are clearly significant links to sex and somewhat significant links to geographic area with the question of whether sex in exchange for something other than money is prostitution. The frequencies and significance levels are described below:

- more women than men (64% vs 50%) consider non-monetary sexual bargaining to be prostitution. The relationship to sex is very significant ($p = .0000$)
- individuals who live in Ontario, Saskatchewan and Alberta have a higher propensity not to consider sex in exchange for something other than money to be prostitution than individuals who live in the Atlantic, Quebec, Manitoba and British Columbia ($p = .1495$). In Alberta, for instance, 55% of respondents considered non-monetary sexual bargaining as prostitution compared to 68% of Atlantic respondents

* No differences in the frequencies are apparent because the skilled, semi-skilled and unskilled occupational group is acting as a confounding factor. This group has more married than single individuals.



- a relationship to occupation was also found, although not statistically significant. Of the five principal occupational groups, the skilled, semi-skilled and unskilled group demonstrate the least agreement to the non-monetary sexual bargaining definition of prostitution. This is a result of the relatively high proportion of males in that occupational group. The homemaker (62%) and office, sales, and service (62%) groups are most in agreement with this definition.

Definition and Explanatory Variables

In order to understand how the definition of prostitution is influenced by the socio-demographic-economic and other variables, a regression analysis was undertaken. Exhibit 3, overleaf, shows the analysis results for the two sexual bargaining definitions under consideration.

Our analysis of the influence of the explanatory variables on the definition of prostitution reveals a strong relationship to general social sexual attitudes. Respondents with more liberal attitudes tend not to define prostitution as the exchange of money for sex or as the exchange of something other than money for sex. These respondents are more inclined to believe in the sexual-moral equality between men and women, to uphold the right to personal freedoms, and to treat homosexuals and heterosexuals with equality. The influence of exposure on how respondents define sex in exchange for something other than money is also significant. Those respondents who know someone who has accepted money for sex do not define non-monetary sexual bargaining as prostitution.

LEVEL OF ACCEPTABILITY

Acceptability of Exchanging Money for Sex

Respondents were asked to indicate how morally acceptable they find the exchange of sexual services for money. As a whole, most respondents indicate this behaviour is unacceptable. Sixty-two per cent of respondents state that

EXHIBIT 3

Definition of Prostitution and Explanatory Variables

Sex in Exchange for Money

<u>Variable</u>	<u>T</u>	<u>Significance Level</u>	<u>Interpretation</u>
Social Sexual Attitude	3.163	.0016	Those that think homosexuals are acceptable as teachers are relatively more likely to think monetary exchange for sex is not prostitution
Occupational Group	2.068	.0390	Skilled, semi-skilled and unskilled occupational group, more than others, think monetary exchange for sex is not prostitution.

Sex in Exchange for Something Other Than Money

Sex	5.580	.0000	Males are more likely to think non-monetary exchange for sex is not prostitution
Social Sexual Attitude	4.333	.0000	Those that agree that a person should be able to do anything as long as it does not harm anyone are more likely to think non-monetary exchange for sex is not prostitution
Social Sexual Attitude	3.491	.0005	Those that do agree a woman should have higher sexual morals than a man are more likely to think non-monetary exchange for sex is prostitution
Social Sexual Attitude	2.154	.0314	Those that agree that the law should enforce sexual morals that agree with their own, are more likely to think non-monetary exchange for sex is prostitution
Exposure	1.819	.0691	Those who know someone who has accepted money for sex are more likely to think non-monetary exchange for sex is not prostitution.



the exchange of sexual services for money is unacceptable in most or all cases compared to 35% who state this is acceptable in some, most or all cases. Our statistical analysis demonstrates that there are significant relationships to sex, community size, religion and employment status with the question of the moral acceptability of exchanging sex for money. Specifically:

- more men (44%) than women (26%) consider this type of behaviour to be morally acceptable. A significance level of $p = .0000$ is found for the sex variable in the model
- community size also influences the level of acceptability tolerated by respondents, with residents of larger communities finding the exchange of sexual services to be more acceptable than those of smaller communities. For instance, 50% of residents in communities with populations less than 5,000 find this behaviour unacceptable, compared to 37% of respondents in communities with populations of 1 million or more
- respondents who did not indicate a religious affiliation judge this behaviour to be more acceptable than others ($p = .0000$)
- employed respondents, more than those who are unemployed, appear to find the exchange of sex for money morally acceptable ($p = .0001$).

Other relationships are found with the level of acceptability towards the exchange of sex for money; however, these are not statistically significant:

- the occupational groups with a preponderance of women (i.e., homemakers and office, sales, service) have more of a tendency to regard this behaviour as unacceptable compared to other groups. As described above, sex has a significant relationship to the acceptability of this behaviour, thereby confounding the relationship of these occupational groups
- young people, more so than older citizens, tend to say that this behaviour is morally acceptable; similarly



those in the higher income brackets with higher education levels, and whose language is English see this behaviour as morally acceptable.*

These socio-demographic-economic relationships are illustrated graphically in Exhibit 4, overleaf.

Acceptability of Exchanging Sexual Services for Something Other than Money

The moral acceptability of the exchange of sexual services for something other than money was investigated. Fifty-three per cent of respondents indicate that this behaviour is unacceptable in most or all cases and 42% indicate acceptability, i.e., they answered it is acceptable in some, most, or all cases.

The influence of key socio-demographic-economic variables on the question of the acceptability of sexual services for something other than money is similar to the earlier question dealing with exchange for money. There is a significant relationship to sex, community size and religion:

- males (31%) more than females (13%) find the exchange of sexual services for something other than money acceptable. The relationship to sex is significant at $p = .0000$
- respondents who did not indicate any religious affiliation find this behaviour more acceptable than those with a religious affiliation ($p = .0000$)

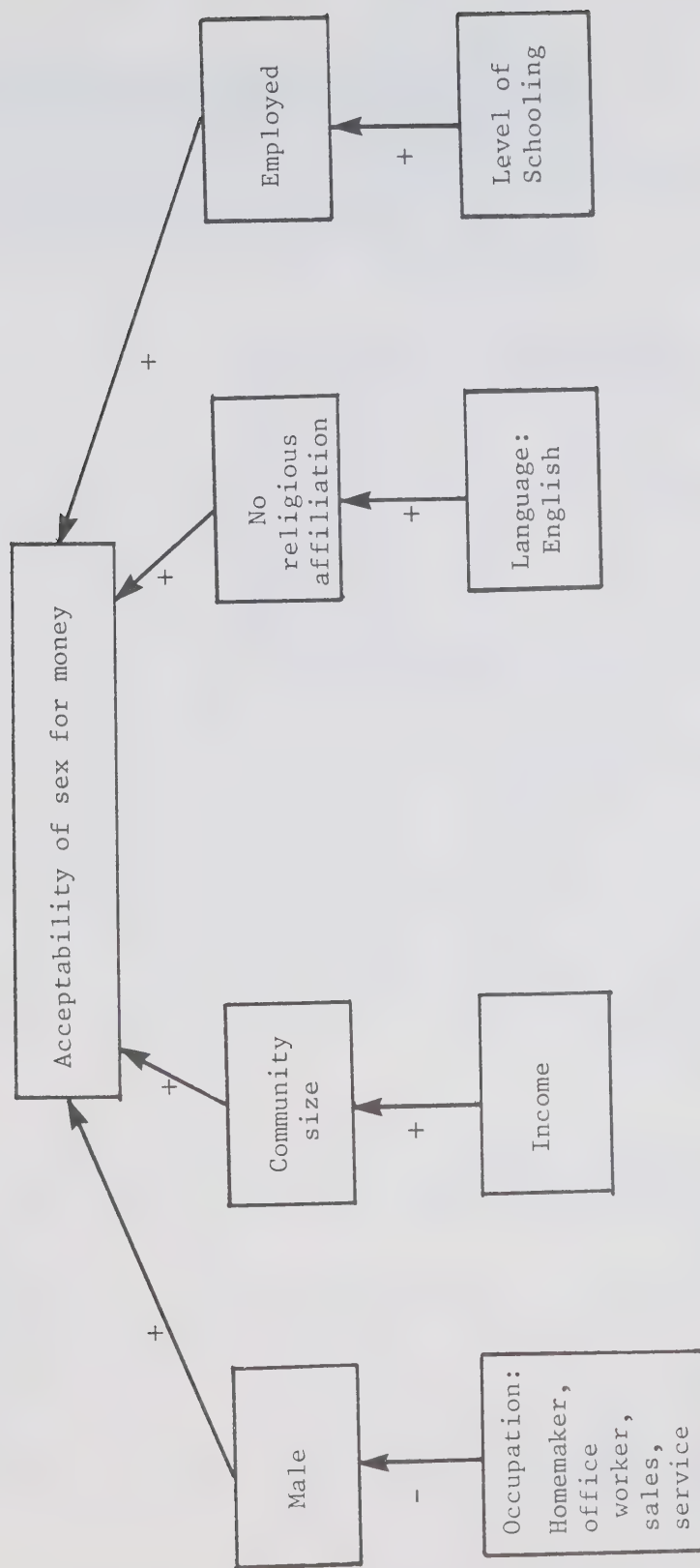
* These variables were not found to be very significant because of their relationship to other more highly significant variables. Age does not appear to be highly significant because it is correlated to employment, income is correlated to employment and community size and education is correlated to community size and employment status.

EXHIBIT 4

EFFECT OF SOCIO-DEMOGRAPHIC - ECONOMIC

VARIABLES ON THE ACCEPTABILITY

OF SEX IN EXCHANGE FOR MONEY





- residents of small communities more than large communities find this behaviour unacceptable ($p = .0000$). For example, 40% of respondents in communities with populations of 5,000 or less indicate that the exchange of sexual services for something other than sex is morally unacceptable, whereas only 28% of respondents in communities of 1 million or more feel the same way.

Level of Acceptability and Definition

Table 1, overleaf, shows graphically the responses for definitions and acceptability. We see that more respondents find these activities unacceptable than acceptable; however, a substantial number do find them acceptable. As well, respondents indicate that the exchange of sexual services for something other than money is more morally acceptable than the exchange of sexual services for money (42% versus 35%). The greater acceptability of these activities appears to be related to what respondents define as prostitution. Respondents find both of these activities more unacceptable when they are defined as prostitution. However as shown in Exhibit 5, overleaf, a substantial number of respondents who consider the exchange of money for sex to be morally acceptable still define it as prostitution (80%). This is similar, although to a much lesser degree, in the case of sex in exchange for something other than money, where 32% of those who find it acceptable consider it to be prostitution.

Level of Acceptability of Sexual Bargaining Activities and Explanatory Variables

The influence of the socio-demographic-economic variables and other explanatory variables on the level of acceptability toward the sexual bargaining activities was examined. Exhibit 6, overleaf, shows the final models for both of the dependent variables under consideration. As may be observed, the level of acceptability towards the dependent variables is related to the same independent variables, with the exception of use and employment status.

The significant relationships (other than with the socio-demographic-economic variables) are described below:

TABLE 1

DEFINITIONS AND ACCEPTABILITY OF PROSTITUTION

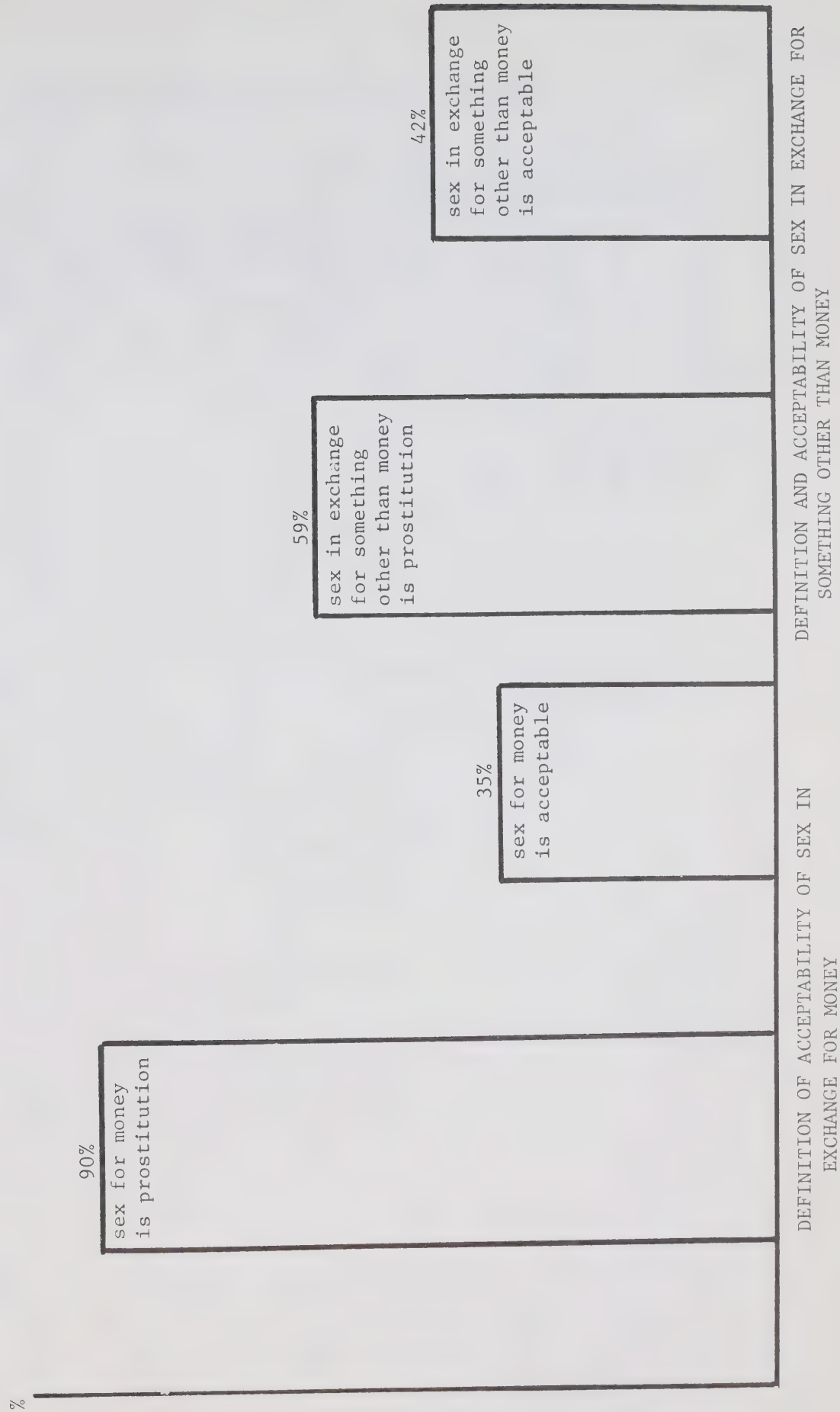


Exhibit 5

Relationship of Acceptability and Definition

(a) Sex in Exchange for Money

How morally acceptable do you consider
sex in exchange for money to be?

		<u>Acceptable</u>	<u>Unacceptable</u>
Would you say that sex between two adults in exchange for money is prostitution?	Yes	566 80%	1200 97%
	No	92 13%	26 2%
	Missing	48 7%	17 1%
	Total	<u>706</u> 100%	<u>1243</u> 100%

(b) Sex in Exchange for Something
Other than Money

How morally acceptable do you consider
sex in exchange for something other than
money to be?

		<u>Acceptable</u>	<u>Unacceptable</u>
Would you say that sex between two adults in exchange for something other than money such as dinner, a gift or a vacation is prostitution?	Yes	275 32%	869 81%
	No	487 57%	128 12%
	Missing	91 11%	76 7%
	Total	<u>853</u> 100%	<u>1073</u> 100%

Acceptability of Sexual Bargaining Activities
and Explanatory Variables

<u>Variable</u>	<u>Sex in Exchange for Money</u>		<u>Sex in Exchange For Something Other Than Money</u>		<u>Interpretation</u>
	<u>T-Value</u>	<u>Significance Level</u>	<u>T-Value</u>	<u>Significance Level</u>	
Exposure	4.301	.0000	-	-	Those who do not know someone who has given money in exchange for sex, less acceptable
Social Sexual Attitudes	4.844	.0000	4.767	.0000	Those who disagree homo- sexual teachers are accept- able as a school teacher as anyone else, less acceptable
Sex	4.966	.0000	7.728	.0000	Females, less acceptable
Social Sexual Attitude	5.459	.0000	4.730	.0000	Those who agree the law should enforce sexual morals that agree with their own, less acceptable
Legal Knowledge	4.606	.0000	3.653	.0003	Those who believe that buying an adult's sexual services is illegal, less acceptable
Social Sexual Attitudes	4.150	.0000	4.730	.0000	Those who disagree a person should be able to do anything as long as it does not harm anyone, less acceptable
Community Size	4.246	.0000	3.444	.0006	Smaller communities, less acceptable
Religion	2.999	.0028	3.823	.0001	Those without religious affiliation, more acceptable
Use	2.976	.0030	-	-	Those who have given money in exchange for sex, more acceptable



Exposure: The level of acceptability toward sexual bargaining activities is linked to exposure to such activities. The relationship to exposure was borne out in the regression analysis, with respondents who have been exposed (either by knowing someone who has given money or accepted money in exchange for sex) indicating a relatively higher acceptability toward sexual bargaining.

This relationship is illustrated in Exhibit 7a, overleaf, where 58% of those who know someone who has accepted money find non-monetary sexual bargaining acceptable compared to 40% of those who do not know such a person that find this activity acceptable.

Social Sexual Attitudes: The importance of the relationship of acceptability and social sexual attitudes is shown in the final models, where three independent variables representing social sexual attitudes are statistically significant. As shown in the interpretation of the model, those with less tolerant social sexual values have a lower level of acceptability towards both dependent variables. This is further demonstrated in Exhibit 7b, overleaf, which shows that those that agree that the law should enforce sexual morals find non-monetary sexual exchange less acceptable than those who disagree with this attitude (36% versus 49%).

Use: Use, which is really an extension of exposure, has a statistically significant relationship with the acceptability of exchanging sex for money. Not surprisingly, those who have given money in exchange for sex find this activity to be more acceptable than those who have not done so.

Legal Knowledge: The relationship of legal knowledge and level of acceptability was examined. The relationship, which was conceptualized (and confirmed in our analysis), indicates that respondents who consider the buying of sexual services illegal find the acceptability of sexual bargaining relatively low. The belief that the legal system does not endorse this activity may influence how respondents feel towards the acceptability of the activity.

EXHIBIT 7

Acceptability of Sexual Bargaining Activities, Exposure and Social Sexual Attitudes

		(a) <u>Exposure</u>		(b) <u>Social Sexual Attitudes</u>			
<u>Level of Acceptability</u>	Do you know anyone who has accepted money in exchange for sex?			The law should enforce sexual morals that agree with my own			
		<u>No</u>	<u>Yes</u>	Neither		<u>Agree</u>	<u>Disagree</u>
				Agree	Nor Disagree		
How morally acceptable do you consider exchanging sex for something other than money?	Acceptable	667 39.8%	175 57.8%	122 36.0%	282 42.9%	276 48.9%	
	Unacceptable	942 56.2%	118 38.8%	209 61.7%	354 53.9%	274 48.6%	
Missing		67 4.0%	10 3.4%	8 2.3%	21 3.2%	14 2.5%	
Total		1676 100.0%	303 100.0%	339 100.0%	658 100.0%	564 100.0%	



Level of Acceptability, Visibility and Activities

Other variables which are thought to affect acceptability levels toward prostitution are:

- the visibility of prostitution activities
- the type of prostitution activities.

The influence of the visibility (location) of prostitution activities and the type of prostitution activities on respondents' attitudes were examined in the survey. Respondents were asked to indicate how acceptable they feel it would be to see different people or scenes in each of a series of places. The people or scenes presented to respondents were:

- prostitutes or street walkers
- bargaining which takes place between prostitute and client
- prostitution sexual services such as sexual intercourse.

The places presented to respondents were:

- open public place (e.g., a park)
- partially visible public place (e.g., a car in a parking lot)
- private place, such as a private apartment
- private commercial place, such as a massage parlor.

The survey results are shown in Exhibit 8, overleaf. It appears that the visibility of the prostitution activity influences the level of public acceptability. There is more tolerance for people or scenes in private places than in public places, although not all public and private places are equally acceptable. Partially visible public places are more acceptable than open

Exhibit 8

Level of Acceptability by Scene
and Location (Visibility)

<u>Location</u>	<u>Level of Acceptability</u>	<u>Prostitutes/ Street Walkers</u>	<u>Bargaining which takes place between a prostitute and a client</u>	<u>Prostitu- tion sexual services</u>
Open public place (e.g., park)	Acceptable	10%	7%	2%
	Neither	9	6	2
	Unacceptable	67	73	80
Partially visible public place (e.g., a car in a parking lot)	Acceptable	15	11	2
	Neither	11	9	3
	Unacceptable	57	61	76
Private place such as a private apartment	Acceptable	45	42	42
	Neither	13	13	11
	Unacceptable	25	28	30
Private com- mercial place (e.g., message parlor)	Acceptable	34	32	26
	Neither	11	10	10
	Unacceptable	38	42	47



public places. Private places such as a private apartment are more acceptable than private commercial places. Some of survey responses supporting these findings are:

- 10% of the respondents indicate the acceptability with viewing a street walker in an open park, versus 15% in a partially visible public place, 34% in a private commercial place and 45% in a private place
- 7% indicate bargaining between prostitute and client is acceptable in an open park, versus 11% who feel this is acceptable in a partially visible public place, 32% in a private commercial place and 42% in a private apartment.

The actual scene or person also appears to influence tolerance levels. Respondents feel that seeing bargaining and sexual services is more offensive than seeing street walkers or prostitutes. This is particularly well exemplified in the case of the open park, where:

- 10% of respondents indicate seeing street walkers would be acceptable, 7% state bargaining would be acceptable and 2% state prostitution sexual services would be acceptable.

However, it also appears that the place where the prostitution activity is seen (visibility) influences how acceptable or unacceptable the prostitution activity is considered to be. This is most noticeable in the case of the private apartment, where the level of acceptability is very similar for each of the people or scenes viewed:

- 45% of respondents indicate that seeing street walkers would be acceptable, 42% of respondents indicate that seeing bargaining or sexual services would be acceptable.



This is not true in the open public place, partially visible public place and private commercial place, where viewing sexual services is much less acceptable than the other three kinds of people or scenes described.

In summary, the examination of the influence of place and scene on level acceptability indicates that:

- the visibility of the prostitution activity influences the level of public acceptability. There is less tolerance for public than private displays of prostitution. There is less tolerance for private commercial establishments than for private places such as private apartments
- the prostitution activity influences tolerance levels. The viewing of prostitution-related activities such as bargaining or the actual sexual service is more offensive than the viewing of the prostitutes or street walkers
- the less visible the prostitution, regardless of the prostitution scene or person, the higher the level of acceptability.

PUBLIC PERCEPTIONS ABOUT PROSTITUTION

A set of questions was incorporated into the survey to elicit respondents' perceptions and attitudes about prostitution. The findings of this examination are described under four sections:

- public perceptions about the harms of prostitution
- public attitudes towards clients and prostitutes
- public perceptions about the economics of prostitution
- public perceptions about the inevitability of prostitution.



Harms of Prostitution

Prostitution is alleged to cause various kinds of social harm. The survey elicited the opinions of respondents regarding a number of these allegations. The results are described according to who is alleged to suffer from the harm.

The aggregate results are shown in Table 2, overleaf.

Harm to Society - Association with Crime and Violence

Although there is no clear link between organized crime and criminal activity (e.g., theft, assault, drug trafficking, etc.) and prostitution, many individuals believe that prostitution has a major influence on criminal activity. The prevalent thinking among the survey respondents is that prostitution is linked to organized crime:

- 60% of respondents think it is linked to organized crime
- 11% of respondents do not think it is linked to organized crime
- 21% of respondents did not have an opinion either way with respect to this issue.

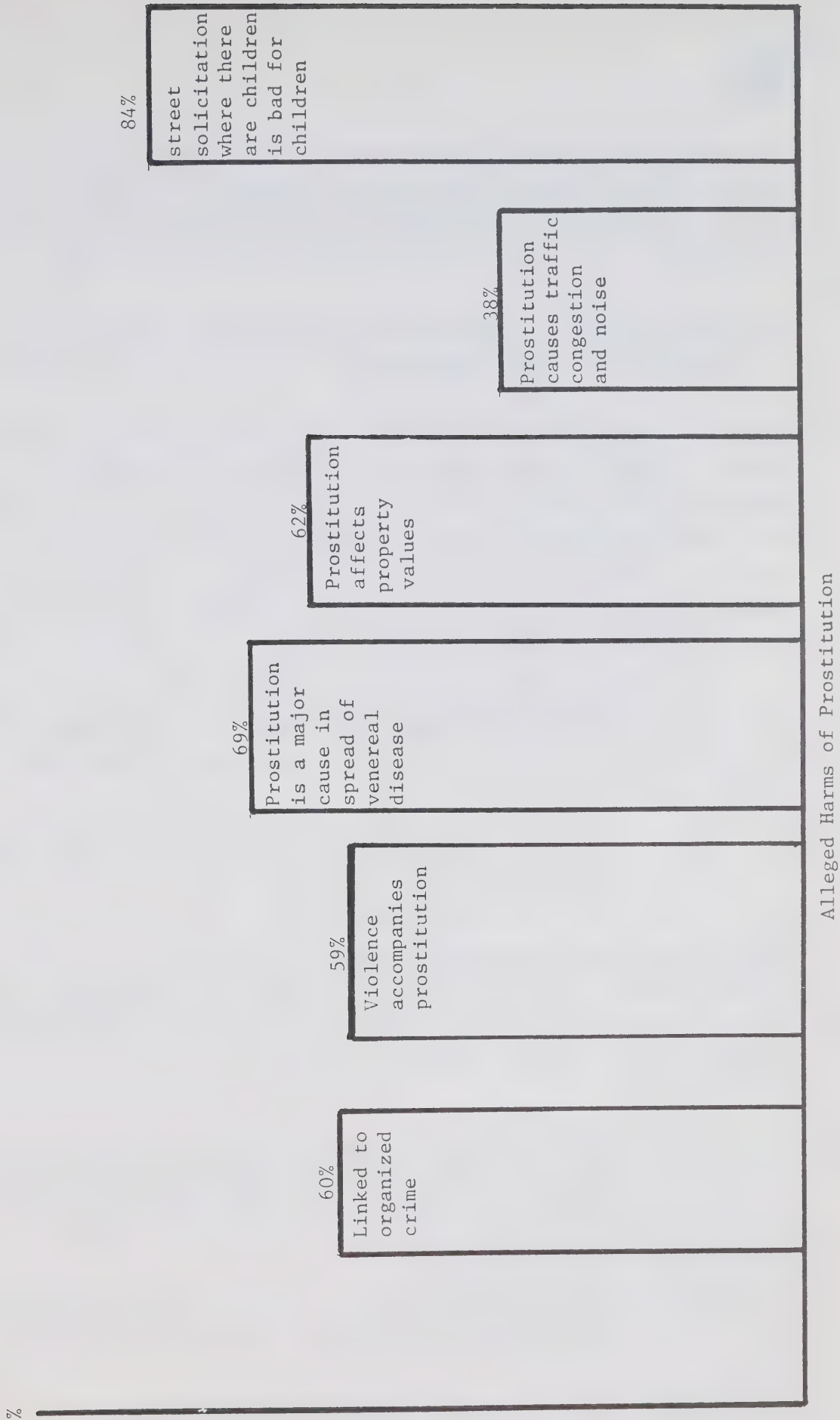
Respondents' association of criminal activity and prostitution is further demonstrated by their responses to the statement violence rarely accompanies prostitution:

- 59% indicate their disagreement with the statement
- 16% indicate their agreement
- 18% neither agree nor disagree with the statement that violence rarely accompanies prostitution.

Two interpretations of the reaction to this statement are possible. On the one hand, respondents may have interpreted violence as part of the type of criminal subculture that prostitution is believed to attract. Respondents may also have

TABLE 2

HARMS OF PROSTITUTION



Alleged Harms of Prostitution



interpreted the violence that accompanies prostitution as the harm and abuse suffered by prostitutes in the hands of customers or pimps. In either case, the responses indicate an association of violence with prostitution activities.

Harm to Society: Spread of
Sexually Transmitted Diseases

There is a concern that prostitution is responsible for the spread of venereal disease. Studies conducted in the U.S. provide evidence that the number of venereal disease cases attributable to female prostitutes is constant and very low. Canadian research provides similar evidence to that found in the U.S., in which case female prostitution is unlikely to be a major cause of the spread of venereal disease. A concern still exists regarding male prostitution and the risk of transmitting AIDS.

The issue of venereal disease and prostitution as a major cause of its spread was investigated by asking the extent of agreement or disagreement regarding the statement:

- prostitution is a major cause in the spread of venereal disease.

Sixty-nine percent of respondents agree with this statement and 20% disagree. According to our statistical analysis, language and occupational group appear to have more influence than any of the other socio-demographic-economic variables on this issue:

- Francophones more than Anglophones feel that prostitution is a major cause in the spread of venereal disease ($p = .0000$). Forty-eight percent of Francophone respondents and 38% of Anglophones agree strongly with this statement
- those respondents in the technical, semi-professional and small business owner and the skilled, semi-skilled and unskilled occupational groups disagree with the



statement more than the other occupational groups ($p = .0068$). For example, 31% of respondents in the technical, semi-professional and small business owner group disagree with the statement compared to 21% in the office, sales and service group.

Other relationships are found with the socio-demographic-economic variables; however, they are not statistically significant:

- females more than males, older more than younger citizens, lower income more than higher income earners and less educated more than higher educated respondents agree that prostitution is a major cause of the spread of venereal disease. Sex, age, income and education are all correlated to the skilled, semi-skilled occupational group
- religion also influences the extent of agreement with the statement, with more Catholics (78%) than Protestants (38%) agreeing. Residents of Quebec reveal the highest level of agreement (82%) with the statement. Both these variables are highly correlated to language.

Harm to Society: Effect on
Neighborhoods, Economic Harm and Public Nuisance

Street solicitation is said to have an effect on residential values. It is also thought to bring about public nuisance problems such as obstruction of streets and sidewalks and increased traffic congestion and noise. The harmful effects of street solicitation on neighborhoods may be as attributable to prostitutes as to customers and on-lookers, although it is not clear how much is attributable to each group.

The views of respondents regarding the effects of prostitution on property values and on traffic congestion and noise were queried. Overall, there appears to be more agreement than disagreement regarding these harmful effects of prostitution. Respondents are more in agreement with the view that street solicitation has a detrimental impact on property values than it does on traffic congestion and noise.



In regard to the effect of prostitution in residential areas on property values:

- 62% agree prostitution does have an effect on property values
- 16% indicate disagreement with this allegation
- agreement on this issue is significantly related to language, marital status, religion and occupation, as shown in Exhibit 9a, overleaf.

In regard to the effect of prostitution in residential neighborhoods on traffic congestion and noise (public nuisance problems):

- 38% agree that prostitution causes traffic congestion and noise (20% disagreed)
- views on this issue are significantly related to geographic area of residence, age, and community size, as shown in Exhibit 9b, overleaf.

Harm to Children

The visibility of street solicitation is considered to be especially harmful to children. Because children are easily influenced and have not formed definitive social sexual values, the effect of prostitution on children is thought to be particularly significant.

Survey participants are inclined to agree that prostitution has harmful effects on children. When asked to indicate the extent of their agreement or disagreement with the statement, street solicitation in areas where there are children is bad for children, it was observed that 84% of the respondents agree, while 6% disagree.

EXHIBIT 9

Relationship of Socio-Demographic-Economic Variables on Views Regarding the Effects of Prostitution

(a) Effect on Property Values

<u>Variable</u>	<u>T-Value</u>	<u>Significance Level</u>	<u>Agreement Direction</u>
French language	7.123	.0000	Francophones, agree
Skilled, semi-skilled and unskilled occupation	4.079	.0000	Skilled, semi-skilled and unskilled occupation, agree
Marital status	3.481	.0005	Married, agree
Protestant	3.100	.0017	Protestants, agree
Clerical, sales and service occupation	2.502	.0125	Clerical, sales, and service occupation, agree

(b) Effect on Traffic Congestion and Noise

<u>Variable</u>	<u>T-Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
Manitoba	4.246	.0000	Manitoba, agree
Age	3.149	.0017	Older, agree
Quebec	3.200	.0014	Quebec, disagree
Community size	2.234	.0250	Larger communities, agree



Views on this issue are significantly related to two socio-demographic-economic variables, marital status and occupational group. Married respondents more than single respondents agree that street solicitation in areas where there are children is bad for children ($p = .0611$). Respondents in the skilled, semi-skilled and unskilled group tend to disagree with this view more than others ($p = .0893$).

Public Attitudes Towards Clients and Prostitutes

There is a concern that society, in general, may be less accepting of prostitutes than it is of the customers who frequent them. The purchase of sexual services is said to be acceptable behaviour, while the provision of these services is said to be abnormal and deviant. Consequently, prostitutes are said to be denied the same social acceptance or status given to their customers.

The application of a double standard between customers and prostitutes was examined with survey respondents. Overall, the opinions expressed in the survey indicate that a double standard is not being applied by a considerable number of respondents. A substantial number of respondents regard prostitute-related activities with equal acceptability to that of customer-related activities.

In order to test the application of a double standard, respondents were given two similar scenarios with different actors (prostitutes and customers). These scenarios were:

- visible solicitation by prostitutes
- men looking for a prostitute.

Respondents were asked to state the degree of offensiveness associated with each scenario. A comparison of the results indicates that there is more offensiveness associated with men looking for a prostitute than with



prostitutes soliciting passers-by. In regard to solicitation by prostitutes, 52% of respondents indicate they would be offended by this behaviour and 42% percent would not be offended at all. In comparison, 56% of respondents indicate they would be offended and 36% would not be offended by men looking for a prostitute.

Our regression model reveals that the level of offensiveness toward prostitutes soliciting passers-by is very much influenced by sex, age, and the geographic area of residence:

- females would be more offended than males (36% versus 16%). The relationship to sex is significant at $p = .0000$
- older citizens would be more offended by this behaviour than younger people ($p = .0000$). Forty percent of respondents over 60 years indicate they would be very offended by solicitation by prostitutes, whereas much fewer respondents in the 18-29 and the 30-44 year age groups would be as offended (22% and 20%, respectively)
- residents of Ontario, ($p = .0000$), followed by residents of the Atlantic, would be more than anyone else ($p = .0218$) offended by visible solicitation. Fifty-six percent of Ontario residents would be offended by prostitutes soliciting passers-by and 54% of Atlantic residents would be similarly offended. The figures in Alberta and Quebec are 43% and 48%, respectively.

As in the previous case, the level of offensiveness toward men looking for a prostitute is significantly related to sex and geographic area of residence. Specifically:

- more women than men would be offended by men looking for a prostitute ($p = .0000$). The survey found that 44% of females would be very much offended by this behaviour, whereas only 19% of males would be similarly offended



- residents of British Columbia and Alberta would be less offended by this behaviour than others ($p = .0844$).

Degradation of Prostitute or Customer

Further evidence that a double standard is not being universally applied is provided by a comparison of responses to the following statements (respondents were asked to indicate their agreement or disagreement):

- prostitution is degrading to prostitutes
- prostitution is degrading to clients.

Prostitution is felt to be similarly degrading to prostitutes as to clients, although slightly more degrading to prostitutes. The following views were expressed by respondents:

- 51% agree that prostitution is degrading to prostitutes, 18% disagree and 24% neither agree nor disagree
- 46% agree that prostitution was degrading to clients, 25% disagree, and 23% neither agree nor disagree.

Responsibility for Acts of Adult Prostitution

The concern that general public attitudes are more aligned against the provider of sexual services than the purchaser was further investigated by asking respondents:

- what persons, if any, are the most responsible for acts of adult prostitution?

As in the previous discussion, the findings indicate similar attitudes expressed towards the prostitute and for the customer:

- 22% feel that customers are most responsible for acts of adult prostitution



- 20% feel prostitutes are most responsible
- 11% feel both customers and prostitutes are mostly responsible for acts of adult prostitution
- 15% feel intermediaries (e.g., pimps, madames, etc.) are most responsible
- 3% indicate prostitutes, clients, and intermediaries are most responsible
- 13% mention other groups or persons: society and the community (3%), government (1%), parents (2%) and societal reasons (7%) such as, unemployment, lack of morals, organized crime, market demand
- 11% indicate they do not know who is responsible
- 4% hold the view that no specific person (or no one) is most responsible for acts of adult prostitution.

These responses are reasonably stable across all socio-demographic-economic variables, with the exception of education. Respondents with higher levels of education felt that customers or clients are most responsible for acts of adult prostitution more than those with lower levels of education.

Public Perceptions About the Economics of Prostitution

A number of social and economic reasons are thought to lead individuals to prostitution. Prostitution is believed to provide high, tax-free incomes which may be more lucrative than other legitimate jobs. A lack of employment opportunities and job skills for the young and insufficient career opportunities for women are also believed to be reasons which lead these groups to prostitution.

Once involved in prostitution, it is believed that many prostitutes turn to pimps and that pimps receive a portion of a prostitute's income in exchange for a variety of services. The number of prostitutes that have pimps and the portion of the prostitute's income given to pimps is unknown.



We investigated the perceptions of survey participants concerning the foregoing issues. The following areas were examined:

- reasons for the occurrence of prostitution
- the financial incentives of prostitution
- the role of pimps in prostitution.

The results are described below in relation to each issue.

Reasons for the Occurrence of Prostitution

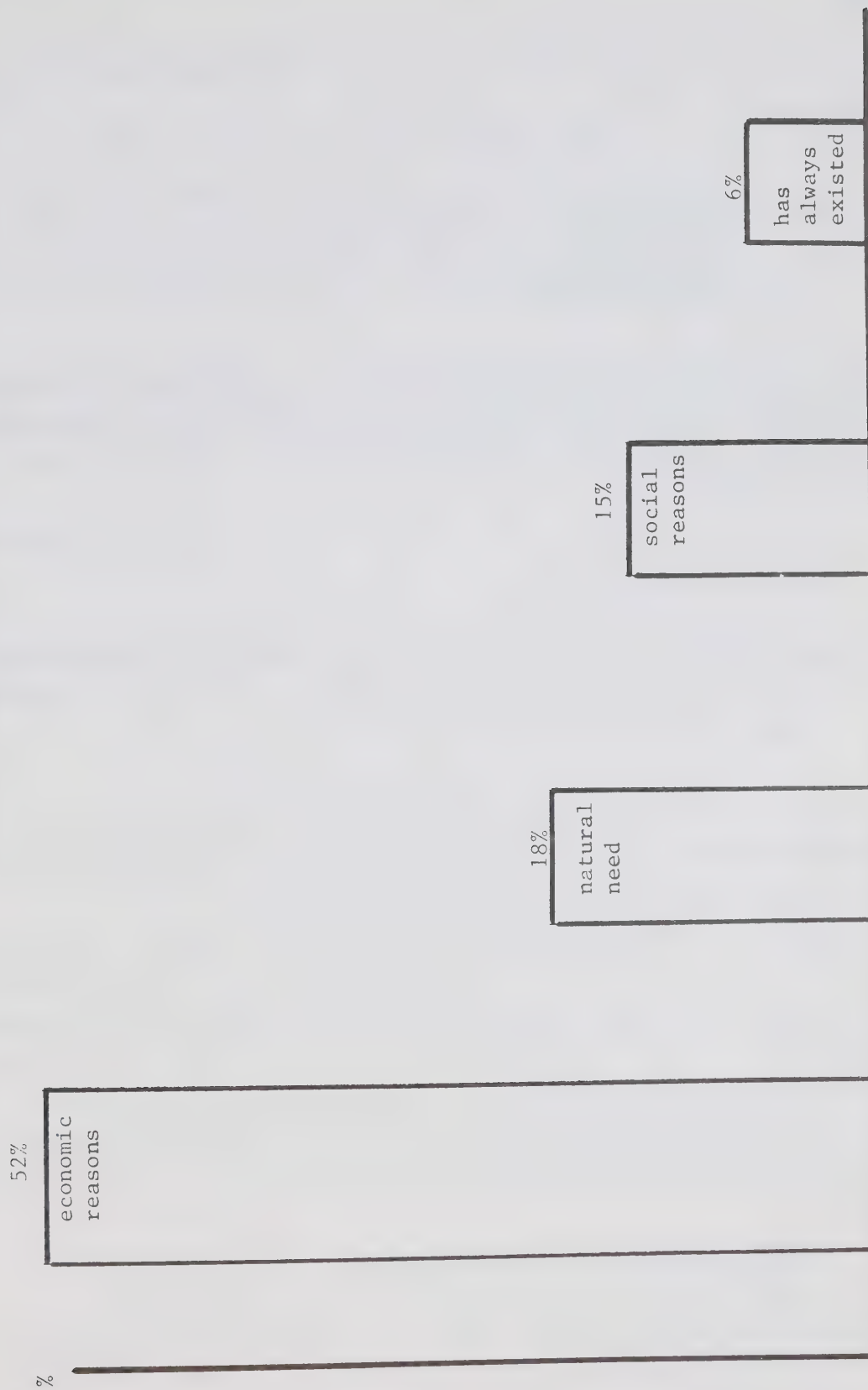
As seen in Table 3, overleaf, our examination of respondents' views on why prostitution occurs reveals that:

- 52% cite a variety of economic reasons for the occurrence of prostitution (e.g., easy and fast way to make money, necessity to survive, due to unemployment, there is a market for that type of work)
- 18% believe prostitution occurs because of a natural, physical need. Many indicate that this need would be most felt by lonesome, shy, or inhibited individuals or those without a sex partner
- 15% cite a variety of social reasons (e.g., present society, lack or lowering of moral values, lack of family support, family breakdown, involved/unacceptable children, unsatisfactory married life)
- 6% indicate that prostitution has always existed and that it is the oldest profession in the world.

The responses indicate respondents put much of the cause for the occurrence of prostitution on economic reasons. Another set of questions in the survey delved more into the economic basis for turning to prostitution.

TABLE 3

CAUSES OF PROSTITUTION



Causes of Prostitution



Respondents were asked to state the extent of their agreement with these statements:

- juveniles resort to prostitution because they can't find jobs
- women become prostitutes because of economic inequalities.

In the first case, 57% of respondents indicate agreement and 16% indicate disagreement. In the second case, 43% of respondents state agreement and 26% disagreement. Again, there appears to be support for the economic basis for turning to prostitution.

Financial Incentives

The survey findings described above provide substantial support for the view that individuals turn to prostitution because it is a means of employment and a way to make money.

The extent to which respondents consider prostitution to be lucrative was examined by asking whether they agreed or disagreed with the statement:

- prostitutes make a lot of money

In responses, 51% of respondents agree, and 15% disagree with the statement. These results indicate that not only do many respondents believe that prostitution is a way to make money, but many also believe there is quite a financial gain to be made. A substantial number of respondents (28%) did not state agreement or disagreement with the statement.

Involvement of Pimps in Prostitution

In order to determine whether survey participants believe that pimps are a part of prostitution activities, they were asked to indicate the extent of their agreement or disagreement with the statement:



- most prostitutes are controlled by pimps

It appears that many respondents believe pimps control prostitutes, with 60% of respondents agreeing and only 8% disagreeing with this statement. There are a substantial number (25%) of respondents who neither agree nor disagree.

This perception is supported by an earlier finding which indicates that 15% of respondents feel that intermediaries (e.g., pimps) are primarily responsible for acts of adult prostitution.

Inevitability of Prostitution

Respondents' perceptions about the inevitability of prostitution was investigated by asking the extent to which they agreed or disagreed with the statement:

- prostitution will always exist no matter what we do

There is strong agreement that prostitution will always exist regardless of what actions are taken. Ninety-two percent of respondents strongly or somewhat agree with the statement. According to our statistical analysis, language and geographic area of residency are the most significant variables influencing perceptions about this statement:

- more Anglophones than Francophones strongly agree that prostitution will always exist no matter what we do (p = .0000). Sixty-five percent of Anglophones indicate agreement with the statement versus 44% of Francophones
- residents of the Atlantic and Manitoba, more than any other provinces, indicate agreement with the statement that prostitution will always exist (p = .0182).



USE PATTERNS

The survey examined the extent to which members of the general public actually participate in activities involving the exchange of money for sex. The frequency with which respondents have given or accepted money in exchange for sex was investigated in the survey. The survey findings (in absolute terms) are shown in Exhibit 10, overleaf.

FREQUENCY OF GIVING MONEY IN EXCHANGE FOR SEX

Most respondents, (96%) state that they have never given money in exchange for sex.* Only 4% of males declare they have done so one or more times. Of the males that have exchanged money for sex, 3% have done so 5 times or less and 1% have done so 21 times or more. A total of 47 males in the sample population have given money in exchange for sex. The cross-tabulations show that no females have given money in exchange for sex. A statistically significant relationship appears with paying for sexual services and two of the socio-demographic-economic variables - sex and geographic area of residency:

- as indicated above, males have more frequently given money in exchange for sex ($p = .0000$)
- residents of B.C., more than others, have given money in exchange for sex ($p = .0273$).

FREQUENCY OF ACCEPTING MONEY FOR SEX

The survey results reveal that only 13 of the respondents have accepted money in exchange for sex. One percent did not answer the question. No relationship with the socio-demographic-economic variables is discerned, probably because of the small number involved.

* Our findings are similar to a February, 1984 preliminary survey conducted for the Department of Justice which found that 95% of the respondents declared never having paid for sexual services of another person and 5% of males having done so once or more. Ninety-nine per cent of females had never paid for sexual services.

Exhibit 10

Absolute Frequency of Giving and
Accepting Money for Sex

<u>Frequency</u>	<u>Have you ever given money in exchange for sex?</u>	<u>Have you ever accepted money in exchange for sex?</u>
Once	19	4
2-5	12	4
6-20	3	1
Greater than 20	7	2
Yes, forget frequency	3	2
Yes, refuse to say frequency	3	0
No	1936	1978
Don't know/no answer	34	28
Total	2018	2018



Use and Explanatory Variables

We analyzed the influence of the socio-demographic-economic and other explanatory variables on the use dependent variable (i.e., paying money in exchange for sex). Our modelling results are shown in Exhibit 11, overleaf. As described above, sex and geographic area of residency are the two significant socio-demographic-economic variables related to the dependent variable. The other variables that were found to be important are described below:

Exposure: Exposure which is gained through the experience of others appears to have a strong influence on the dependent variable. Knowing someone who has given money in exchange for sex is positively related to giving money in exchange for sex. This is illustrated in Exhibit 12a, overleaf, where respondents who do not know someone who has paid for sex are less likely to have paid for sex than those who do know someone (99% versus 89%).

Public Concepts: Three variables representing public concepts are found to be related to the dependent variable. Not surprisingly, those that find it acceptable to exchange money for sex tend to have done so. Respondents who do not feel anyone is responsible for acts of adult prostitution (i.e., do not put the blame on prostitutes, customers, pimps, etc.) are more inclined to have exchanged money for sexual services. Finally, there is a positive relationship with those that believe prostitution is linked to organized crime and those who have paid for sex. It appears that users tend to have relatively wide levels of acceptability but at the same time have some definite perceptions about prostitution operations.

Exhibit 12b, overleaf, illustrates the relationships of the dependent variable with a public concepts variable. Respondents who find paying for sexual services acceptable tend to have done so more than those who find this unacceptable (5.3% versus .8%).

EXHIBIT 11

Exchange of Money for Sex and Explanatory Variables

<u>Variable</u>	<u>T-Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
Exposure	5.320	.0000	Those who know someone who has given money for sex are more likely to have paid money in exchange for sex
Sex	3.648	.0003	Males, more than females have given money in exchange for sex
Victim of Sexual Offense	3.161	.0016	Those that have been a victim of a sexual offense tend to have paid money in exchange for sex
Public Concepts	2.533	.0015	Those who find giving money in exchange for sex acceptable, have done so more than others
Public Concepts	2.386	.0172	Those who do not think anyone is responsible for acts of adult prostitution tend to have paid money in exchange for sex
Area of Residency	2.109	.0352	British Columbia residents, more than others, have paid money for sex
Social Sexual Attitudes	2.009	.0440	Those that think sex education should never be started in schools tend to have paid money in exchange for sex
Public Concepts	1.744	.0815	Those that believe prostitution is linked to organized crime, tend to have paid money in exchange for sex

Exhibit 12

Exchange of Money for Sexual Services, Exposure and Public Concepts

		(a) <u>Exposure</u>		(b) <u>Public Concepts</u>	
		<u>Do you, personally, know anyone who has given money in exchange for sex?</u>		<u>How morally acceptable do you consider the exchange of sexual services for money?</u>	
		<u>No</u>	<u>Yes</u>	<u>Acceptable</u>	<u>Unacceptable</u>
Have you ever given money in exchange for sex?	No	1523 98.6%	372 89.2%	659 93.4%	1219 98%
	Yes	5 .3%	42 10.1%	37 5.3%	10 .8%
	Missing	16 47%	3 .7%	9 1.3%	14 1.1%
	Total	1544	417	706	1243
		100.0%	100.0%	100.0%	100.0%



Victim of Sexual Offense: Respondents who indicate having been a victim of sexual offense are relatively more likely to have paid money in exchange for sex.*

Social Sexual Attitudes: A positive relationship is found with those that think sex education should never be started in school and those that have paid money in exchange for sex. This implies that these respondents have fairly conservative social sexual attitudes.

DEGREE OF EXPOSURE TO PROSTITUTION-RELATED ACTIVITIES

The degree of exposure to prostitution-related activities was assessed in two ways. First, the survey examined respondents' awareness of solicitation and prostitution activities in their surroundings. Then, the survey focussed on obtaining a measure of the extent to which respondents are exposed to prostitution activities through their acquaintances' involvement in such activities.

EXPOSURE TO SOLICITATION

Exposure was assessed in the survey by focussing on respondents' awareness of prostitution activities. This examination did not allow us to determine whether solicitation does occur and respondents are not aware of its existence in their surroundings. Respondents' awareness of solicitation activities in their surroundings and the frequency of this occurrence was investigated in relation to:

- solicitation for the purposes of prostitution on the streets of their residential neighborhood
- solicitation for the purposes of prostitution on the streets in the area where they do their grocery shopping

* Overall, 10% of survey respondents indicate they have been a victim of a sexual offense. Of these, 13% are female and 7% are male. A definition of what constitutes a sexual offense was not provided in the survey.



- except for solicitation on the streets, other areas in their municipality where prostitution takes place.

Exposure to solicitation on the streets of respondents' residential neighborhoods is not substantial. Seventy-five percent of respondents never see solicitation on the streets of their residential neighborhood and 72% never see the same activity in the area where they do their shopping. Four percent of the respondents often or sometimes are exposed and 8% are rarely exposed to solicitation in their residential neighborhoods. This is similar to the visibility of solicitation in the streets where respondents normally do grocery shopping. Six percent often or sometimes are exposed and 9% are rarely exposed to this activity in their shopping area.

According to our regression model, sex is the only significant variable related to exposure to solicitation on residential streets ($p = .0361$). More females than males indicate they have never seen solicitation in their residential area (77% versus 73%). Community size and geographic area of residency appear to have some link to the frequency of exposure to solicitation in residential streets, although the relationship is not statistically significant. Residents of smaller communities observe solicitation for the purposes of prostitution less often than residents of larger communities. Residents of British Columbia and Alberta, more than the other provinces, state that solicitation in their residential neighbourhood never occurs. The relationship of exposure with community size and geographic area is examined further in Exhibit 13, overleaf. We see that:

- among the provinces, respondents who are most aware of solicitation (i.e., see it often, sometimes or rarely) reside in Quebec, the Atlantic and Ontario
- among major urban centres in Canada, respondents who are most aware of solicitation (i.e., see it often, sometimes, or rarely) in their residential areas, reside in Halifax, followed in frequency by Montreal, Vancouver and Toronto

Exhibit 13

Frequency of the Visibility of Solicitation for the Purposes
of Prostitution in Respondents' Residential Neighbourhood by
Province and Selected Major Centre

<u>Region/ Major Centre</u>	<u>Frequency of Visibility of Solicitation for the Purposes of Prostitution on Residential Streets</u>				
	<u>Often</u>	<u>Sometimes</u>	<u>Rarely</u>	<u>Never</u>	<u>Don't Know</u>
Halifax	2.9%	4.8%	12.5%	65.4%	13.5%
Rest of Atlantic	1.0	2.0	9.3	81.5	5.9
Montreal	2.0	7.1	10.1	77.4	3.0
Rest of Quebec	1.6	4.1	9.3	71.9	12.7
Toronto	-	2.0	9.8	62.2	25.2
Rest of Ontario	2.5	4.2	5.9	75.3	11.8
Manitoba	-	1.6	9.9	79.3	8.4
Saskatchewan	1.2	1.1	5.8	76.7	15.2
Edmonton and Calgary	-	-	6.7	76.7	12.7
Rest of Alberta	-	-	9.8	88.2	-
Vancouver	.9	1.8	11.6	77.7	8.0
Rest of B.C.	-	-	3.5	87.1	8.6



- the residents of the major centre in a province are more aware of solicitation than are residents of the rest of the province. The one exception is in Ontario, where solicitation is seen more often in the rest of the province than in Toronto.

Community size, geographic area of residency and marital status appear to have a significant relationship to the extent of exposure to solicitation in shopping areas. Residents of smaller communities indicate having observed solicitation for the purposes of prostitution less often than residents of larger communities ($p = .0001$). Ontario residents see this activity more than residents of the other provinces ($p = .0017$). Single individuals observe solicitation occurring in the area where they shop more often than married individuals ($p = .0174$).

In regard to respondents' awareness of other areas in their municipality where prostitution takes place, 55% have no knowledge of such areas. The regression model reveals that language ($p = .0031$) is the only significant socio-demographic-economic variable influencing awareness of areas where prostitution takes place. Anglophones are generally less knowledgeable than Francophones, with 59% and 44%, respectively, indicating they do not know other areas. There are other relationships with the dependent variable, although these are not statistically significant. Older citizens more than young people, and Protestants more than Catholics are unaware of other areas where prostitution took place. The same relation is found for residents of small communities versus large communities. Regarding area of residence, residents of the Atlantic, Ontario and the West are less aware of places where prostitution take place than Quebecers (in keeping with the language relationship).

Of those respondents who are aware of other areas where prostitution takes place, 14% cite bars/hotels/motels while 6% do not specify the locations. Fourteen percent of respondents do not know whether there are any other areas in their municipality where prostitution takes place.



Overall, the findings indicate that awareness about prostitution activities is not widespread and it appears to be higher in specific provinces and larger communities.

EXPOSURE THROUGH EXPERIENCE OF OTHERS

The survey investigated the exposure to prostitution activities which is gained by sharing the experience of family, friends or acquaintances who have been involved in these activities. First, respondents were asked whether they personally knew anyone who had accepted money in exchange for sex. Then, they were asked to indicate whether they personally knew anyone who had given money in exchange for sex.

On the question of whether respondents knew anyone who had accepted money in exchange for sex, 15% respond affirmatively and 83% respond negatively. A significant relationship is found with three socio-demographic-economic variables, religion, marital status and geographic area of residency:

- respondents who do not indicate a religious affiliation are more likely than others to know someone who has accepted money in exchange of sex ($p = .0000$)
- residents of Alberta tend to know someone who had accepted money more than residents of the other provinces ($p = .0000$). The survey findings show that 25% of Albertans know someone who has accepted money in exchange for sex compared to 12% of residents in the Atlantic or 13% in Quebec
- single people tend to know someone who has accepted money for sex more than married people ($p = .0006$). Eighteen percent of singles versus 13% of married respondents know such individuals



- although not statistically significant, there is also a relationship to age, with younger people more than older citizens tending to know someone who has accepted money in exchange for sex.*

Slightly more respondents know someone who had given money in exchange for sex than someone who has accepted money in exchange for sex. Twenty-one percent of respondents indicate that they know someone who has given money in exchange for sex and 77% do not know anyone who has done so.

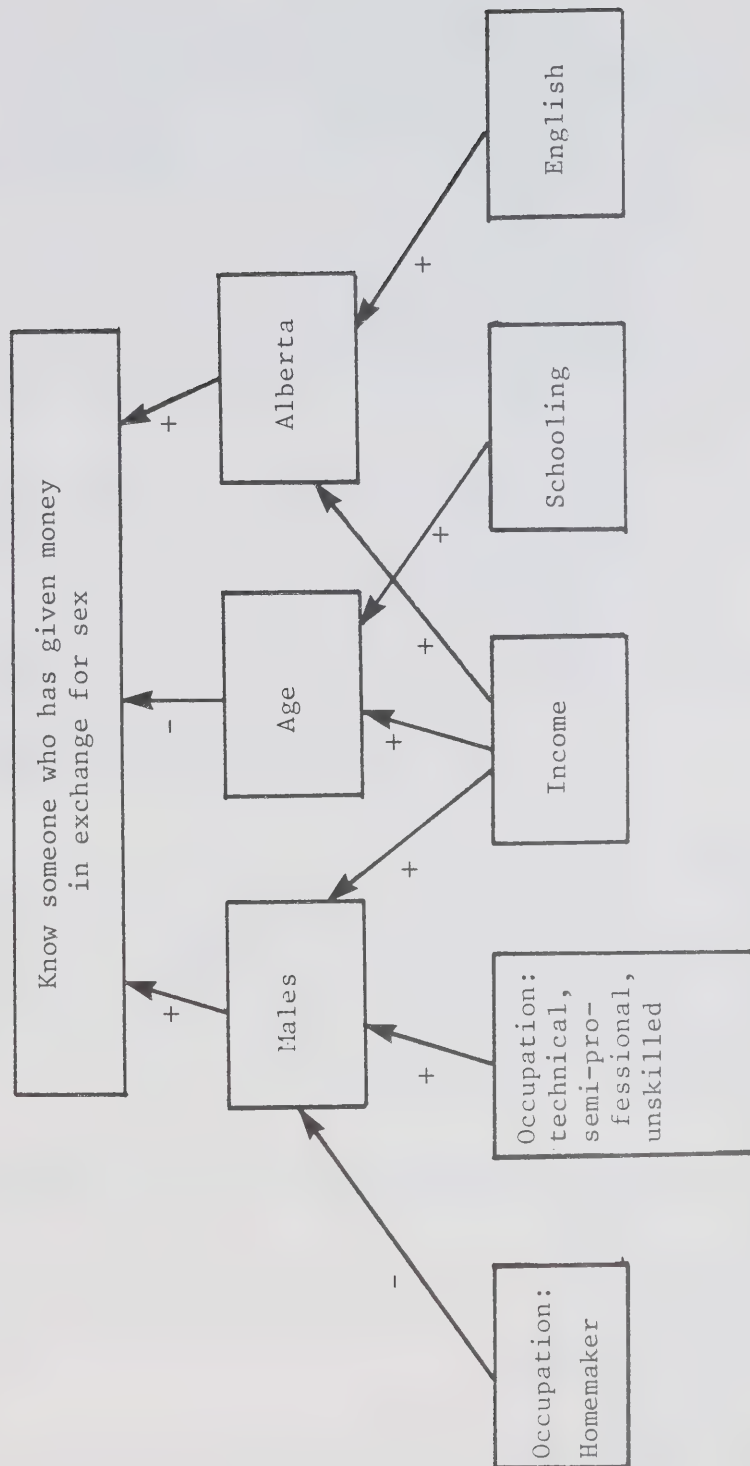
A number of relationships are found among those who declared knowing someone who has given money in exchange for sex and the socio-demographic-economic variables. These are illustrated in Exhibit 14, overleaf. It is observed that:

- there is a significant relationship with sex ($p = .0000$). More males (29%) than females (13%) know someone who has given money in exchange for sex
- younger people know someone who has paid for sex more than older citizens ($p = .0000$). Only 8% of respondents in the 60+ age group declare knowing such individuals compared to 28% of respondents in the 18-29 age group
- Albertans, more than residents of the other provinces, know someone who has paid for sex ($p = .0000$). The figures show that 33% of Albertans know someone compared to 15% of Quebecers, 17% of Atlantic residents and 22% of Ontarians. We see there is some commonality among respondents who know someone who has given money in exchange for sex and who has accepted money in exchange for sex. Albertans know someone who has participated in these sexual bargaining activities more than residents of other provinces.

* Respondents who indicate no religious affiliation also tend to be young. Thus, the strength of the relationship with religion confounds the age relationship.

EXHIBIT 14

EFFECT OF SOCIO-DEMOGRAPHIC - ECONOMIC
VARIABLES ON KNOWING SOMEONE WHO HAS
GIVEN MONEY IN EXCHANGE FOR SEX





- respondents with higher incomes and with higher education know individuals who paid for sex more than those with low incomes and less education. No statistically significant relationship is found with income and education since both are related to age. The high significance of age in the regression model confounds the relationship of income and education
- Anglophones know someone who has given money for sex more than Francophones (23% versus 14%). This language relationship is probably explained by the high proportion of Anglophones in Alberta and that residents of that province are more inclined to know someone who has paid for sex
- with respect to occupational groups, the technical, semi-professional and small business owner group (32%), followed by individuals in the skilled, semi-skilled and unskilled group (26%) have the highest knowledge of individuals who have given money in exchange for sex, only 13% of homemakers know such individuals. The former two groups have a relatively high proportion of males. The sex distribution found among these occupational groups probably explains the differences found in knowledge of individuals who have paid for sex.

Aggregate exposure (exposure to solicitation and through experience of others) results are illustrated in Table 4, overleaf. We see that respondents are being exposed to prostitution activities more by their acquaintances (who have given money for sex) than by the actual visibility of solicitation in their neighbourhoods or shopping areas.

LEGAL KNOWLEDGE ABOUT PROSTITUTION-RELATED ACTIVITIES

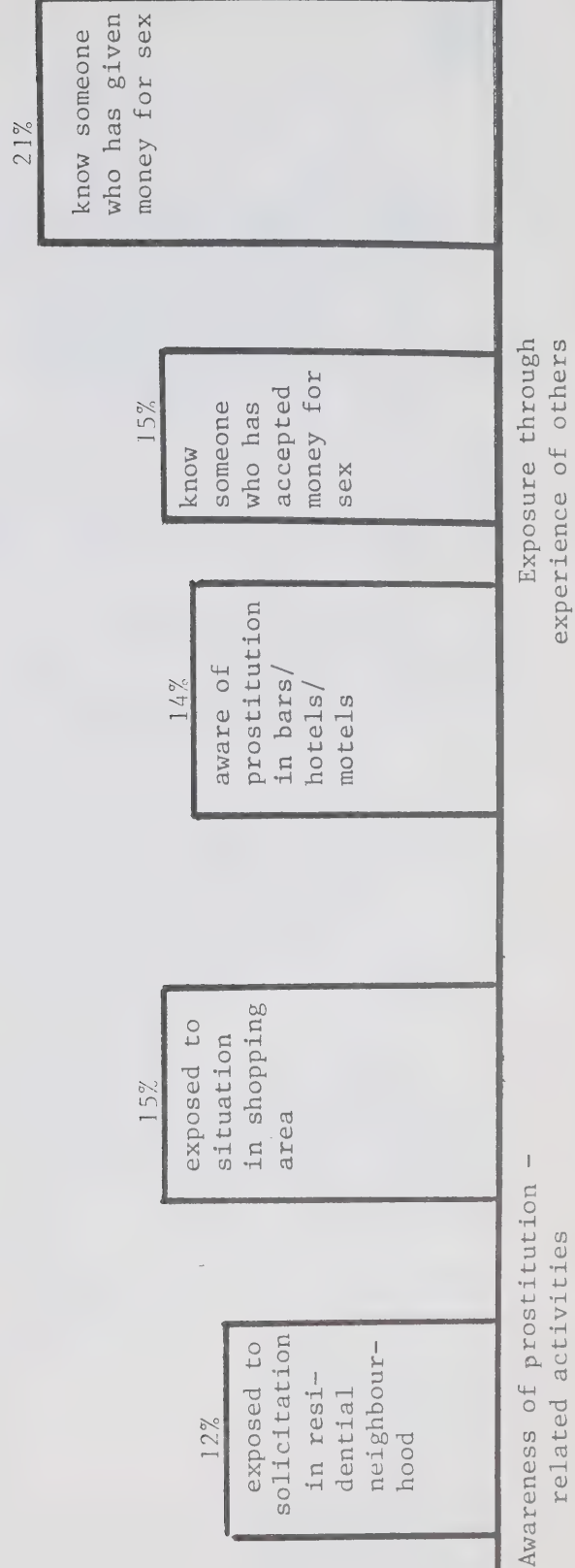
Awareness of the facts or legal knowledge was obtained by asking respondents to indicate the legality of a number of activities. Six activities were presented, as shown below:

- 1) The buying of an adult's sexual services in private.
- 2) An adult selling his or her own sexual services in a brothel.
- 3) Pressing or persistent solicitation for the purposes of prostitution.

TABLE 4

EXPOSURE TO PROSTITUTION - RELATED ACTIVITIES

% of
Respondents
Exposed





- 4) An adult buying the sexual services of children.
- 5) An adult arranging for the prostitution of children.
- 6) An adult arranging for the prostitution of other adults.

The first situation, the buying of an adult's sexual services in private is legal. As well, the fourth situation, an adult buying the sexual services of children, is legal in certain situations*.

The regression analysis results of the examination of legal knowledge are presented in Exhibit 15, overleaf. Little commonality can be observed in how the socio-demographic-economic variables are influencing legal knowledge.

Most respondents are not aware that the first activity -- the buying of an adult's sexual services in private -- is legal. In this case, 22% of the sample population state that the activity is legal and 67% state it is illegal. Nine percent of respondents do not know whether this is a legal or illegal activity.

Those that correctly know the activity is legal are inclined to be in the professional occupational group. Other relationships with the dependent variable are revealed, although these are not statistically significant. Those that know the activity is legal tend to be between 30-59 years of age, have a high income and be more highly educated. Age, income and education are highly correlated to the professional occupational group.

* It is legal if there is no pressing and persistent solicitation in a public place, and (1) if the youth is a male and there is no gross indecency and there is consent, or (2) the youth is 14 but under 16 years of age and there is no gross indecency, and she is not previously of chaste character.

EXHIBIT 15

Relationship of Socio-Demographic-Economic
Variables on Legal Knowledge

<u>Activity</u>	<u>Variable</u>	<u>T-Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
Buying an Adult's Sexual Services in Private	Occupation	5.993	.0000	Professionals, big business owners, administrator occupational group, legal
Adult Selling His or Her own Sexual Services in a Brothel	Age 60+	3.643	.0003	Age over 60 years, legal Ontario and Atlantic, illegal
	Ontario/Atlantic	2.886	.0040	
	Sex	1.793	.0731	Males, legal
Pressing or Persistent Solicitation for the Purposes of Prostitution	Marital Status	1.783	.0747	Married, legal
Adult Buying Sexual Services of Children	Occupation	3.095	.0020	Technical, small Business owner, semi-professional occupational group, legal
	Education 0-8	2.395	.0178	Education up to 8 years, legal
	Ontario	2.067	.0390	Ontario, legal
Adult Arranging for the Prostitution of Children	Alberta Employment	2.220 1.874	.0266 .0611	Alberta, legal Employed, illegal
	Marital Status Religion Employed	2.595 1.775 1.724	.0095 .0760 .0849	Married, illegal Catholics, legal Employed, legal



With respect to the second activity (an adult selling his or her own sexual services in a brothel), 84% of the respondents indicate it is illegal while 8% indicate it is legal. Seven percent of the respondents do not know the legality of this activity. Our regression analysis indicates that there are three statistically significant relations with the socio-demographic-economic variables: age, geographic area of residence and sex.

Ninety-one percent of respondents state that the third activity (pressing or persistent solicitation for the purposes of prostitution) is illegal and only 3% state it is legal. Five percent of respondents do not know the legality of this activity. One significant relationship is found with the socio-demographic-economic variables. Marital status has an influence in the legal knowledge about this activity, with 91% of married versus 89% of singles correctly responding. Although the difference in frequencies between males and females is not large, the influence of marital status on the dependent variable is very significant ($p = .0000$).

Respondents are overwhelmingly unanimous in their thinking about the legality surrounding prostitution activities and children. An adult buying the sexual services of children is almost unanimously felt to be illegal by respondents (97%). Although this situation is legal in certain circumstances, the phrasing of the question was perhaps too general for respondents to distinguish the subtleties of the law. It is more probable that respondents believe all activities related to prostitution and children are illegal given that 97% of respondents also feel that an adult arranging for the prostitution of children is illegal. A relationship is revealed with the occupation, education and area of residency for the first of these activities and with employment status and area of residency for the second.

The last activity, an adult arranging for the prostitution of other adults, is indicated as being illegal by 90% of respondents. Four percent of the respondents believe this activity is legal while 5% do not know of its legality. There is a statistically significant relationship with three of the socio-demographic-economic variables - marital status, religion, and employment status.



In summary, most respondents have a good knowledge about the law surrounding four activities (2, 3, 5 and 6, above) and few are knowledgeable about the two remaining activities (1 and 4, above). One interpretation of these findings is that respondents have a good appreciation and knowledge of the legality or illegality of most of these activities. However, it is more probable that respondents think that all aspects of prostitution are illegal, given that most declared all six activities to be illegal and that many could not distinguish the one prostitution activity which is legal or the activity which is legal in certain circumstances.

PREFERENCES FOR POLICY OPTIONS

In regard to the control over prostitution, the survey investigated respondents' opinions about the adequacy of the current legal system and their preferences for options to deal with this issue. Their views regarding the specific role of government to deal with adult and child prostitution, as well as the need for police control in the area of adult street prostitution were obtained. Finally, respondents' attitudes regarding certain prostitution operations were assessed, in order to obtain an understanding of the type of legalization schemes they find acceptable.

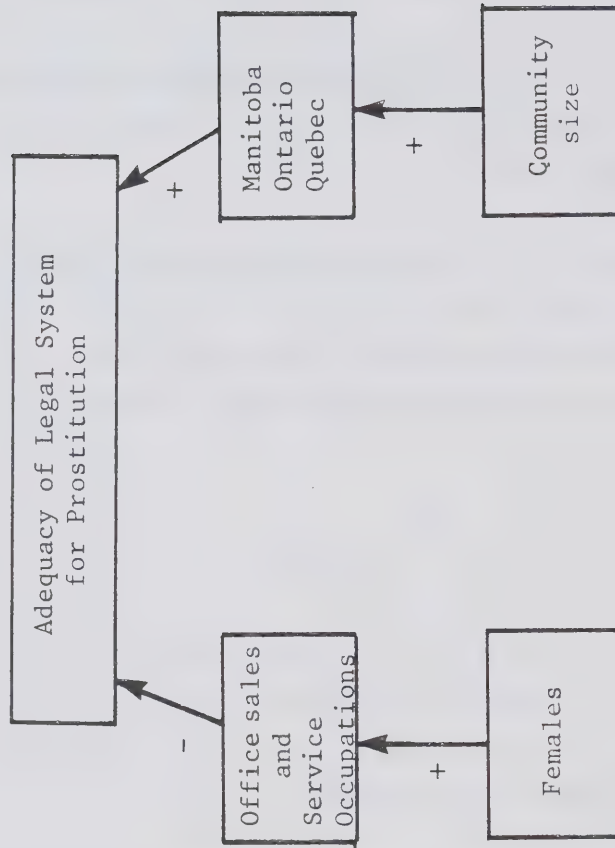
ADEQUACY OF CURRENT LEGAL SYSTEM

Respondents were asked to indicate whether the current legal system dealt adequately with prostitution. Overall, 64% of respondents feel that the legal system does not deal adequately with prostitution while 22% are of the opposite opinion. Twelve percent of respondents do not know whether the current system deals adequately with prostitution.

The results of our analysis of the influence of the socio-demographic-economic factors are shown in Exhibit 16, overleaf. These indicate there are a number of significant relationships to the question of the adequacy of the legal system:

EXHIBIT 16

EFFECT OF SOCIO-DEMOGRAPHIC - ECONOMIC
VARIABLES ON THE ADEQUACY OF LEGAL SYSTEM FOR
PROSTITUTION





- those in the office, sales and service occupational group more than any other occupational group feel that the legal system is not adequate ($p = .0288$)
- residents of Manitoba, Ontario and Quebec more than any of the other provinces feel that the legal system is adequate ($p = .0403$). For example, 20% of Quebec respondents declare their satisfaction with the current legal system compared to only 13% in British Columbia
- more males than females (27% versus 18%) find the current legal system adequate. These sex differences are not found to be significant, largely because of the positive correlation of sex to the office, sales and service occupational group. Females are predominant in the make-up of this group
- community size is positively related to feelings of legal adequacy, although this is not statistically significant.

Adequacy of the Legal System and Explanatory Variables

The adequacy of the legal system and its relationship to the socio-demographic-economic variables and other explanatory variables is shown in Exhibit 17, overleaf. The final model described in the Exhibit indicates the following variables have a significant relationship to the question of the adequacy of the legal system:

Public Concepts: Respondents with fairly tight acceptability levels and who agree that prostitution has harmful effects tend to feel the legal system adequately deals with prostitution. These respondents tend to believe that violence accompanies prostitution and are offended by men looking for a prostitute. Similarly, these respondents define non-monetary sexual bargaining as prostitution. Exhibit 18a, overleaf, illustrates the relationship of

EXHIBIT 17

Adequacy of the Legal System and Explanatory Variables

<u>Variable</u>	<u>T-Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
Public Concepts	3.689	.0002	Those that say non-monetary exchange for sex is prostitution, system not adequate
Public Concepts	2.943	.0033	Those that believe violence accompanies prostitution, system not adequate
Victim of Sexual Offence	2.402	.0166	Those who have been a victim of a sexual offence, system not adequate
Public Concepts	2.061	.0397	Those who are offended by men looking for a prostitute, system not adequate
Geographic Area of Residency (Manitoba, Ontario, Quebec)	1.984	.0476	Residents of Manitoba, Ontario, and Quebec, system adequate
Social Sexual Attitudes	2.012	.0446	Those that do not feel a person can do anything as long as it doesn't harm anyone, system not adequate
Occupational Group (Clerical, sales and service)	1.732	.0837	Clerical, sales and service occupation group, system not adequate

EXHIBIT 18

Adequacy of Legal System to Deal with Prostitution, Public Concepts and Social Sexual Attitudes

		(a) Public Concepts			(b) Social Sexual Attitudes		
		Violence rarely accompanies prostitution			A person should be able to do anything as long as it doesn't harm others		
		Neither Agree Nor Disagree			Neither Agree Nor Disagree		
Adequacy of Legal System		Agree	Disagree	Disagree	Agree	Disagree	Disagree
Do you believe the legal system deals adequately with prostitution at this time?	No	150 56.4%	169 58.4%	695 71.3%	460 60.3%	182 69.3%	399 72.5%
	Yes	79 29.8%	80 27.9%	26 23.3%	215 28.2%	45 17.0%	95 17.2%
	Missing	37 13.9%	40 13.7%	95 9.8%	88 11.6%	36 13.8%	56 10.2%
Total		266 100.0%	289 100.0%	974 100.0%	763 100.0%	263 100.0%	550 100.0%



public concepts to the dependent variable. Respondents who do not think violence accompanies prostitution are more likely to think the legal system is adequate than those that do not share this public concept (71% versus 56%).

Victim of Sexual Offense: Respondents that have been a victim of a sexual offence, more than others, find that the legal system deals inadequately with prostitution.

Social Sexual Attitudes: Respondents with more conservative social sexual attitudes are more inclined to feel the system is inadequate. A personal liberty variable (a person can do anything as long as it doesn't harm anyone), was found to have the most significant relationship with the dependent variable. Exhibit 18b, overleaf, provides a clearer picture of the relationship. Seventy-three percent of those that disagree that a person can do anything think that the legal system is inadequate compared to 60% that do not have this social sexual attitude.

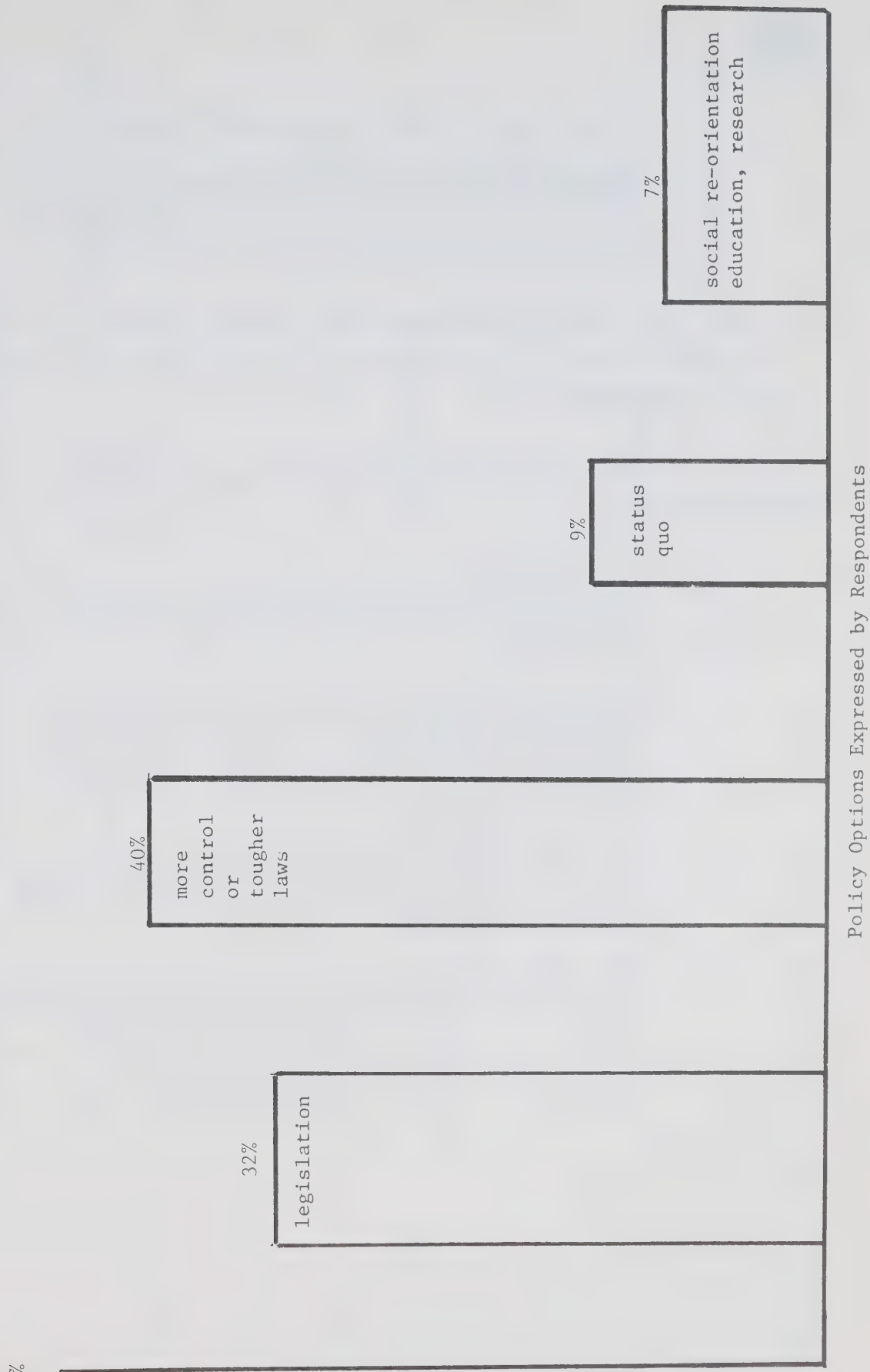
OPTIONS TO DEAL WITH PROSTITUTION

The previous question did not allow us to determine in what manner the legal system is inadequate (i.e., whether it is currently too strict, too lax, just right, etc.). In order to investigate respondents' attitudes toward the current legal system, the survey pursued the issue by asking what they felt should be done about prostitution. Responses to this question broke down into four major options which are shown in Table 5, overleaf, and described below:

- legalization or legalization with controls: 32% suggest this option
- creation of tougher laws and controls: 13% suggest more control is necessary to deal with prostitution, 14% indicate the need to create tougher laws, and another 13% indicate various forms of tougher controls (e.g., arrest, fine prostitutes, get rid/ban prostitution). Overall, 40% suggest this option

TABLE 5

PREFERENCES FOR POLICY OPTIONS FOR PROSTITUTION





- status quo: 9% feel nothing should be done
- social reorientation/education/research: 3% feel social reorientation is necessary, 3% feel people should be educated and 1% feel the topic should be studied and researched.

The link to the various socio-demographic-economic variables differed according to the option selected by respondents as described below, and summarized in Exhibit 19, overleaf.

Those that indicate some type of legalization is required have the following characteristics:

- Catholic respondents more than others do not favour a legalization approach ($p = .0001$). For example, 24% of Catholics opt for legalization compared with 34% of Protestants
- residents of large communities more so than small communities favour legalization ($p = .0000$). For example, the figures are 40% in communities with populations larger than one million and 23% in communities with populations under 5,000
- geographic differences appear among proponents of legalization. B.C. and Alberta residents are most supportive (53% and 46%) of this option, ($p = .0000$ for both provinces)
- the office, sales and service occupational group more than others do not favour a legalization approach ($p = .0007$). Only 25% of these respondents favour legalization. The professional and technical occupational groups show the highest support for legalization (41% and 47% respectively)

EXHIBIT 19

PROFILE OF THOSE FAVOURING DIFFERENT POLICY OPTIONS FOR PROSTITUTION

	<u>Legalization</u>	<u>Tougher Laws</u>	<u>Status Quo</u>	<u>Social Re-orientation, Education, Research</u>
Province	B.C. - yes Alberta - yes	Atlantic - yes	B.C. - yes	
Religion	Catholic - no	No religions affiliation - no		
Community Size	Larger - yes			
Occupation	Office, sales, services - no	Office, sales, service - yes Skilled, semi- skilled, unskilled - yes	Professional - yes	
Married	Married - yes	Married - no		
Language	Francophones - no	Francophone - yes	Francophone - no	Francophone - yes
Schooling				More schooling - yes
Sex			Males - yes	



- 33% of married respondents and 23% of single respondents suggest legalization, at a significance of $p = .0099$
- Anglophones (34%) more than Francophones (23%) support this view. The language relationship is not statistically significant, however, because of the strength of the relationship of religion and geographic area of residency.

Those that favour tougher laws have the following relation to the socio-demographic-economic variables:

- more Francophones (39%) favour a tougher stance than Anglophones (22%). The relationship to language is significant at $p = .0000$
- there are regional differences among respondents with this view. The most support for this option came from the Atlantic ($p = .0000$). For example, 36% of Atlantic residents favour tougher laws, while 15% of B.C. residents indicate the same
- the office, sales, service, followed by the skilled, semi-skilled and unskilled occupations show the most support for tougher laws ($p = .0000$ and $p = .0016$, respectively)
- those without a religious affiliation are least supportive of tougher laws ($p = .0130$).

Respondents that indicate a status quo approach have the following relation to the socio-demographic-economic variables:

- Francophones are least inclined to support a status quo approach ($p = .0000$). 12% of Anglophones and 4% of Francophones feel that no measures are necessary



- residents of B.C., more than others, are least inclined to support this option ($p = .0001$). The survey reveals 5% of B.C. residents stated a status quo approach compared to 12% Ontario
- males more than females support the status quo option (12% and 7%, respectively, at $p = .0194$)
- the professional occupational group support this option least ($p = .0834$). For example, only 6% of respondents in the occupational group support this view, compared to 11% in the office, sales and service group.

The significant links to the socio-demographic-economic variables found with those who indicate a social reorientation/education/research option are:

- respondents with greater than 14 years of schooling are most inclined to state this option ($p = .0037$)
- Francophones opt for this approach more than Anglophones ($p = .0111$).

Policy Options to Deal with Prostitution and Explanatory Variables

We analyzed the influence of the socio-demographic-economic and other variables on the four major policy options suggested by respondents to deal with prostitution. Exhibit 20, overleaf, indicates the results of our regression analysis; the major relationships (other than with the socio-demographic-economic variables) are discussed below.

In examining the effect of the explanatory variables, we see that public concepts and social sexual attitudes are the most common explanatory variables related to the four policy options. The options chosen by respondents are influenced by the level of acceptability they have towards prostitution-related activities, by their perceptions about prostitution and by their general attitudes toward personal liberties and social sexual values.

EXHIBIT 20

Policy Options to Deal with
Prostitution and Explanatory Variables

<u>Variable</u>	<u>T-Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
<u>Legalization</u>			
Public Concepts	6.943	.0000	Those who find sex in exchange for money acceptable, legalization
Area of Residency	4.677	.0000	British Columbia, legalization
Public Concepts	4.237	.0000	Those who are not offended by solicitation of passers-by, by prostitutes, legalization
Social Sexual Attitude	3.672	.0003	Those who think sex education should be started in primary school, legalization
Area of Residency	3.332	.0009	Alberta, legalization
Exposure	2.031	.0426	Those who least often see solicitation on the streets, where they do grocery shopping, legalization
Community Size	2.345	.0193	Larger communities, legalization
Marital Status	2.053	.0405	Married, legalization
Public Concepts	1.789	.0741	Those that think prostitution has an effect on residential property values, legalization
Occupation Group	1.654	.0986	Clerical, sales and service occupation, do not want legalization
<u>Creation of Tougher Laws and More Controls</u>			
Public Concepts	7.446	.0000	Those who find sex in exchange for money unacceptable, tougher laws
Public Concepts	3.534	.0004	Those who are offended by solicitation of passers-by, by prostitutes, tougher laws
Language	3.664	.0003	Francophones, tougher laws
Area of Residency	2.662	.0079	Atlantic, tougher laws
Legal Knowledge	2.542	.0112	Those who believe buying of an adults' sexual services is legal, tougher laws
Occupation Group	3.491	.0005	Skilled, semi-skilled and unskilled, tougher laws
Occupation Group	3.357	.0008	Clerical sales and service occupation, tougher laws
Public Concepts	2.497	.0127	Those who agree prostitution is degrading to prostitutes, tougher laws
Social Sexual Attitudes	1.781	.0752	Those who do not think sex education should be started in primary schools, want tougher laws

EXHIBIT 20 (Cont.'d)

<u>Variable Legalization</u>	<u>T-Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
Status Quo (Nothing should be done)			
Language	4.677	.0000	Francophones, not the status quo
Public Concepts	2.542	.0112	Those who do not think that prostitution has an effect on residential property values, status quo
Social Sexual Attitudes	2.441	.0149	Those who do not agree a person should be able to do anything as long as it doesn't harm anyone, not the status quo
Area of Residency	2.678	.0076	British Columbia, not status quo
Social Sexual Attitudes	2.215	.0271	Those who think sex education should be started in secondary school or after, status quo
Public Concepts	1.770	.0771	Those who do not think prostitution is a major cause in the spread of venereal disease, status quo
Social Reorientation/Education/Research			
Public Concepts	3.705	.0002	Those who disagree prostitution will always exist do matter what is done, social reorientation/education/research
Public Concepts	2.607	.0093	Those who are offended by men looking for a prostitute, not social reorientation/education/research
Education	2.613	.0091	Schooling more than 14 years, social reorientation/education/research
Public Concepts	2.139	.0327	Those who define sex in exchange for money as prostitution, not social reorientation/education/research
Language	2.095	.0365	Francophones, social reorientation/education/research



For example, we see that proponents of legalization have wide levels of acceptability and more liberal social sexual attitudes compared to proponents of the more control option. They are more inclined to find the exchange of money for sex acceptable and are relatively less offended by solicitation of passers-by. Proponents of legalization and more control both concede that there are harmful effects associated with prostitution (i.e., effect on residential property values and degradation of prostitutes), yet, they propose quite different options to deal with these effects - in the first case some type of regulated controls and in the second case tighter laws and enforcement. With respect to social sexual attitudes, proponents of legalization have fairly liberal views, as shown in their preference to have sex education begin in primary school compared to proponents of the more control option, who are less inclined to share this preference.

We see that proponents of the status quo option have fairly liberal attitudes toward personal freedoms. They are more inclined to disagree with the harmful effects attributable to prostitution (i.e., on residential property values and on spreading venereal disease) which may explain their preference for the status quo. They are more inclined to prefer sex education be started in secondary school or higher than the proponents of the other three options, indicating a somewhat conservative social sexual attitude.

Proponents of the social reorientation/education/research option have fairly wide acceptability levels, as evidenced by their tendency not to be offended by men looking for a prostitute and not to define sex in exchange for money as prostitution. Like proponents of legalization and more control, they believe that prostitution has harmful effects (i.e., street solicitation where there are children is bad for children) and suggest a social reorientation/education/research approach to deal with such effects. They are less inclined to agree that prostitution will always exist no matter what is done (perhaps believing that through social orientation, education and research that it can be dealt with most appropriately).



ROLE OF GOVERNMENT IN DEALING WITH PROSTITUTION

In order to implement some of the options above, some type of leadership on the part of government (and others) would be required. The specific role of government in dealing with prostitution was investigated with respondents. They were asked to indicate whether or not the government should undertake various activities to deal with prostitution. The results of this investigation are shown in Exhibit 21, overleaf, and are discussed below. The activities about which respondents were asked to comment fall within the realm of the four major policy options described above.

More control and tougher laws: The need to toughen the laws against prostitutes is expressed by 62% of respondents. Only 17% of respondents feel that the prostitutes should be left alone but that customers should be prosecuted while many more, (50%) feel that prostitutes should be left alone and pimps should be prosecuted.

Legalization: A number of variations on a legalization approach are assessed by respondents (i.e., creation of zoning laws, licensing and requirement for medical examinations). The requirement to have prostitutes undergo medical examinations is supported by 82% of respondents. The substantial support expressed for the government in this area may stem from the concern held that prostitution is a major cause in the spread of venereal disease.

The role of the government in creating zoning laws and requiring prostitutes to have licenses is supported by a similar proportion of respondents, 61% and 63%, respectively.

Social Reorientation: The role of the government in alleviating the causes of prostitution is supported by a substantial number of respondents. Fifty-seven percent of respondents express the need to increase social services and 59%

EXHIBIT 21

ROLE OF GOVERNMENT IN DEALING WITH PROSTITUTION

<u>Proposed Role</u>	<u>Yes</u>	<u>No</u>
Increase social service funds	59%	33%
Increase social services	57	36
Not do more than now	35	54
Create zoning laws to restrict prostitution activity	61	31
Leave prostitutes alone but prosecute customers	17	72
Leave prostitutes alone but prosecute pimps	50	41
Require prostitutes to have license	63	28
Require prostitutes to have medical examinations	82	10
Make the law tougher against prostitutes	62	29
Decriminalize prostitution-related activities	40	47



express the need to increase social services funds to deal with those who are involved in prostitution.*

Government Status Quo: The option that the government do no more than it is now doing is supported by the fewest respondents (35%). The previous section showed that only 9% of respondents opted for a status quo approach. The difference in the frequencies may be many explained by respondents' desire to have the government do no more but still have other changes.

Another 40% of respondents indicate that prostitution-related activities should be decriminalized. It is difficult to determine whether respondents could distinguish between the various legalization options and decriminalization.

ROLE OF LOCAL POLICE

The previous discussion indicates that a considerable number of respondents feel the need for tougher laws and controls to deal with adult prostitution. The support for tougher controls was further shown when examining the role of local police in the control of adult street prostitution:

Seventy-one percent of respondents believe that the police should have more or much more power, 20% believe they should have neither more nor less power and 6% believe they should have less or much less power.

Our analysis found that education and religion have a significant relationship to the dependent variable:

- respondents with less than eight years of schooling more than others feel that the police should have more power to control prostitution ($p = .0000$). Forty-four

* Because of a translation error, French questionnaires asked whether the government should increase social service funds and the English questionnaires asked whether the government should increase social services to deal with those who are involved in prostitution. It appears respondents interpreted the two questions in a similar manner, since responses are very much the same.



percent of respondents who have completed eight years of schooling feel more police power is required, compared to 30% and 22% who have completed 9-13 years and over 14 years of schooling, respectively

- respondents who did not indicate a religious affiliation more than others are of the opinion that less police power needs to be exercised ($p = .0000$)
- older citizens more than young people, and low income earners more than high income earners feel the police should have more power. Age and income, however, are not found to be statistically significant.

ATTITUDES TOWARD VARIOUS PROSTITUTION OPERATIONS

As described above, some form of legalization of prostitution activities appeals to a significant number of respondents (32%). A legalization approach would probably involve the licensing of prostitutes or the establishments where prostitution takes place (or both).

In order to get a better understanding of the type of legalization schemes most acceptable to respondents, they were asked to indicate whether certain prostitution operations/activities should be allowed to operate. Exhibit 22, overleaf, depicts the responses declared for five types of prostitution operations:

- street solicitation for the purposes of prostitution
- brothels
- all forms of prostitution, but only in designated areas of town
- prostitution on private premises
- escort and call-girl services.

Prostitution on private premises, escort call-girl services, and brothels receive the most support, with 45%, 43% and 38% of respondents respectively, indicating these should be allowed to operate. Only 28% feel prostitution should be allowed to operate in designated areas of town and still less (11%)

Exhibit 22

Attitudes Toward Various Prostitution Operations

<u>Type of Operation/Activity</u>	<u>Should It be Allowed to Operate?</u>		
	<u>Yes</u>	<u>No</u>	<u>No Answer</u>
Street solicitation for the purposes of prostitution	11%	84%	4%
Brothels	38	55	6
All forms of prostitution but in designated areas of town	28	67	5
Prostitution on private premises	45	52	4
Escort and call-girl services	43	52	4



feel street solicitation for the purposes of prostitution should be allowed to operate.

The more discrete forms of prostitution activities appear to elicit greater support from respondents than more openly visible types of prostitution. This finding is supported by other survey results which show that more private displays of prostitution elicit a higher level of acceptability from respondents.

ROLE OF GOVERNMENT IN DEALING WITH CHILD PROSTITUTION

Exhibit 23, overleaf, describes the results of a question dealing with the role of the government in the area of child prostitution. The need to do more than is currently being done now is expressed by 80% of the respondents. The actions which respondents feel should be taken are described below:

- tougher laws: most respondents feel that laws should be toughened against child prostitution pimps (93%) and customers (89%). Much fewer (50%) feel that laws against children should be toughened, indicating perhaps that respondents place the responsibility for child prostitution with pimps and customers more than with the children. Tougher laws against the adult prostitute are more widely expressed than for the child prostitute, although both received substantial support.
- increase social service funds or social services (see footnote, p. II.40) 86% feel that funds should be increased in the social services area to deal with children involved in prostitution and 79% feel social services should be increased. There appears to be a strong desire to focus on alleviating the causes that bring children to participate in prostitution.

The findings of the survey clearly indicate that there is concern with the phenomenon of child prostitution and a feeling that government should take more action than is currently being taken. It is also apparent that there is much more concern in the area of child prostitution than adult prostitution. The need for tougher laws and increased social services efforts is more widely supported for child prostitution than for adult prostitution.

Exhibit 23

Government Role in the
Area of Child Prostitution

<u>Proposed Role</u>	<u>Yes</u>	<u>No</u>	<u>No Answer</u>
Increase social service funds to deal with children involved in prostitution	86%	12%	2%
Increase social services to deal with those involved in prostitution	79	15	5
Do no more than in being done now	12	80	8
Toughen laws against the child prostitution pimps	93	2	4
Toughen laws against the customer	89	7	4
Toughen laws against the children	50	44	6



SUMMARY OF SURVEY FINDINGS REGARDING PROSTITUTION ISSUES

Summary findings are described in relation to the five major issue areas elaborated in the foregoing chapter. We then review the influence of the explanatory variables (e.g., the socio-demographic-economic variables, public concepts, exposure, legal knowledge).

PUBLIC CONCEPTS

- Although there is not unanimous support for this definition, the majority of respondents (90%) consider the exchange of sex for money to be prostitution. Fifty-seven percent of respondents also consider sex in exchange for something other than money to be prostitution.
- The prevalent thinking is that the exchange of sex for money or for something other than money is unacceptable. A substantial number of respondents; however, find both of these sexual exchange activities acceptable (35% and 42%, respectively).
- The prostitution activity influences levels of acceptability, with the viewing of prostitution-related activities such as bargaining or the actual sexual service being more offensive than the sight of prostitutes or street walkers.
- There is less tolerance for public displays of prostitution than private displays.
- The prevalent thinking among respondents is that prostitution does have harmful effects. The greatest degree of consensus was indicated with respect to the harmful effects of prostitution on children.
- The attitudes expressed by respondents toward prostitutes and clients indicate that they are generally viewed with equal regard and that a double standard is not being applied.



- Over half of the respondents put much of the cause for the occurrence of prostitution on economic reasons. There is a similar number of respondents who believe prostitution is lucrative.
- The vast majority of respondents (92%) believe that prostitution will always exist no matter what actions are taken.

USE

- Ninety-six percent of the survey respondents state that they never gave money in exchange for sex. A total of 47 respondents or 4% of the males in the sample have done so one or more times. Less than 1% or 13 of the respondents have accepted money in exchange for sex.

EXPOSURE

- Exposure to solicitation activities on either streets of respondents' residential neighbourhoods or where they do grocery shopping is infrequent, localized in larger centres, and regionally-specific.
- Respondents are being exposed to prostitution activities more by their acquaintances than by the actual visibility of solicitation in their neighbourhoods or shopping areas. For example, the figures indicate 21% of respondents know someone who has given money for sex, and only 14% see solicitation in their residential neighbourhood.
- The proportion of respondents who know someone who has accepted or given money in exchange for sex (15% and 21%, respectively) is much greater than the proportion who have accepted or given money in exchange for sex themselves.

LEGAL KNOWLEDGE

- The vast majority of respondents believe all aspects of prostitution are illegal. In particular, respondents are overwhelmingly unanimous in their belief that activities related to children and prostitution are illegal.



POLICY OPTIONS

- A substantial number of respondents (64%) find the legal system deals inadequately with prostitution. A further examination of what respondents feel should be done about prostitution reveals that inadequate does not necessarily mean they desire a harsher stand against the issue. We found that legalization and tougher laws are preferred by a similar proportion of respondents (32% and 40%, respectively). A non-legal approach is preferred by 7% of the respondents (e.g., research, social reorientation, etc.) and another 9% of respondents are satisfied with the current situation.
- A substantial number of respondents support the need to toughen the laws against adult prostitutes (62%).
- A number of variations on a legalization approach for adult prostitution are supported by many respondents, including the creation of zoning laws (61%) and the requirement to have prostitutes have licenses (63%) and medical examinations (82%). The requirement to have prostitutes undergo medical examinations probably stems from the concern many respondents (69%) have that prostitution is a major cause of the spread of venereal disease (a concern which, according to U.S. and Canadian research, is unjustified).
- A substantial number of respondents (58%) feel government should have a role in alleviating the causes of adult prostitution through social services.
- Decriminalization is supported by 40% of respondents; however, we could not determine whether respondents could distinguish this option and the various legalization options.
- There is much more concern in the area of child prostitution than adult prostitution. The need for tougher laws and increased social services efforts is more widely supported for child prostitution than for adult prostitution.



- Most respondents feel that laws should be toughened against child prostitution pimps (93%) and customers (89%) and a much fewer (but still substantial) number (50%) feel that the laws against child prostitutes should be toughened. Tougher laws against the adult prostitute are more widely expressed than for the child prostitute, although both received substantial support (62% and 50%, respectively).
- Of five prostitution operations, respondents find least unacceptable prostitution on private premises, followed in order and by escort call-girl services, brothels, prostitution in designated areas of town and street solicitation. The more discrete forms of prostitution activities appear to elicit greater support than more openly visible types of prostitution.
- The role of police in controlling adult prostitution is supported by 71% of respondents.

Influence of the Explanatory Variables on Prostitution Issues

The influence of the socio-demographic-economic and other explanatory variables on selected prostitution dependent variables are summarized in Exhibit 24, overleaf. In order to integrate the various relationships shown in the Exhibit we developed two models which are a wrap-up of the influences and interactions among the explanatory variables. The models are shown in Exhibits 25 and 26, overleaf, and depict the relationships influencing the two major prostitution control options -- legalization and more control. The major highlights are as follows:

- those preferring legalization tend to be married, less exposed to solicitation, from larger cities, and with a relatively higher proportion in British Columbia and Alberta. They tend to be in occupations other than offices, sales, and service, have liberal social sexual attitudes, and tend to find prostitution acceptable

Exhibit 24

RELATIONSHIP OF SELECTED PROSTITUTION DEPENDENT VARIABLES AND SIGNIFICANT EXPLANATORY VARIABLES*

EXPLANATORY VARIABLE	DEPENDENT VARIABLE						
	Definition of Sex in Exchange for Money as Prostitution	Acceptable to Exchange Money for Sex	Offended by Men Looking for a Prostitute	Prostitution has Effect on Property Values	Exposed to Solicitation in Shopping Areas	Have Exchanged Money for Sex	Prefer Legalization to Deal with Adult Prostitution
Sex		Males, agree	Females, yes			Males, yes	Prefer more Control and Tougher Laws to Deal with Adult Prostitution
Age							
Language				(Francophones, yes)			(Francophones, no)
Occupational Group	Skilled, semi-skilled and unskilled, no			Skilled, semi-skilled and unskilled, yes			Office, sales, service, no
Geographic Area of Residency	(Atlantic, yes)		British Columbia, Alberta, no	Office, sales and service occupation, yes	Ontario, more exposed	(B.C., yes)	B.C., yes Alberta, yes
Employment Status		Employed, agree					
Religion		No religion, agree		Protestants, yes			(Catholic, no)
Community Size		Larger cities, agree			Larger cities, more frequent		Larger cities, yes
Marital Status	(Married, yes)			Married, yes	Married, yes		(Married, no)
Social Sexual Attitudes	More liberal attitudes, no	More liberal attitudes, agree				Conservative social sexual values, yes	More liberal attitudes, yes
Public Concepts						Wide acceptability, yes	Wide acceptability, yes Prostitution has harmful effects, yes
Use		Exchange money for sex, agree					
Exposure						Know someone who has given money for sex, yes	See solicitation less, yes
Legal Knowledge		Aware of legalities, agree					Aware of legalities, yes
Victim of Sexual Offense						Have been victim, yes	

* Variables in brackets did not appear in the final model which combines socio-demographic-economic variables with other explanatory variables.

Relationship of Preference for Legalization and Explanatory Variables

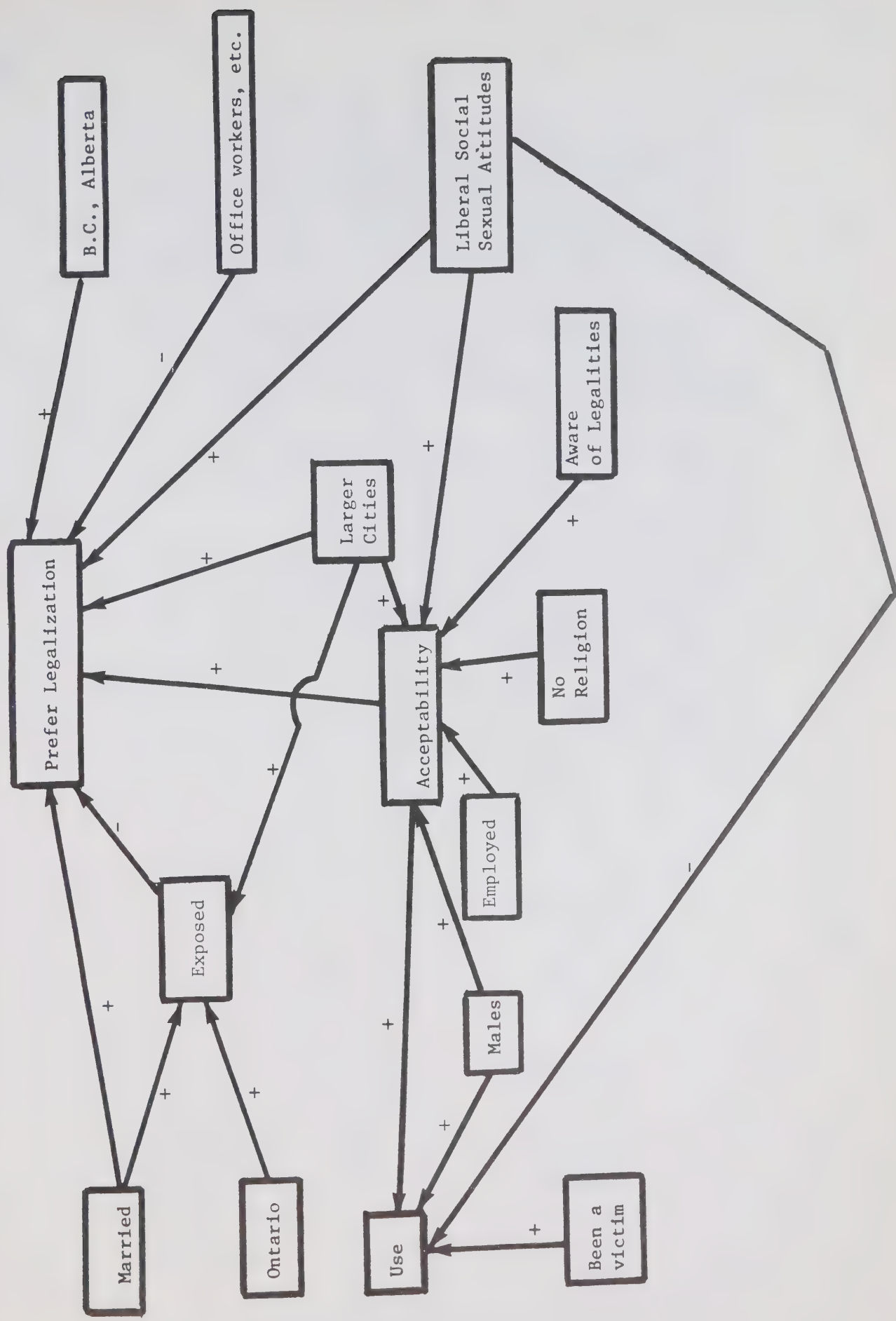
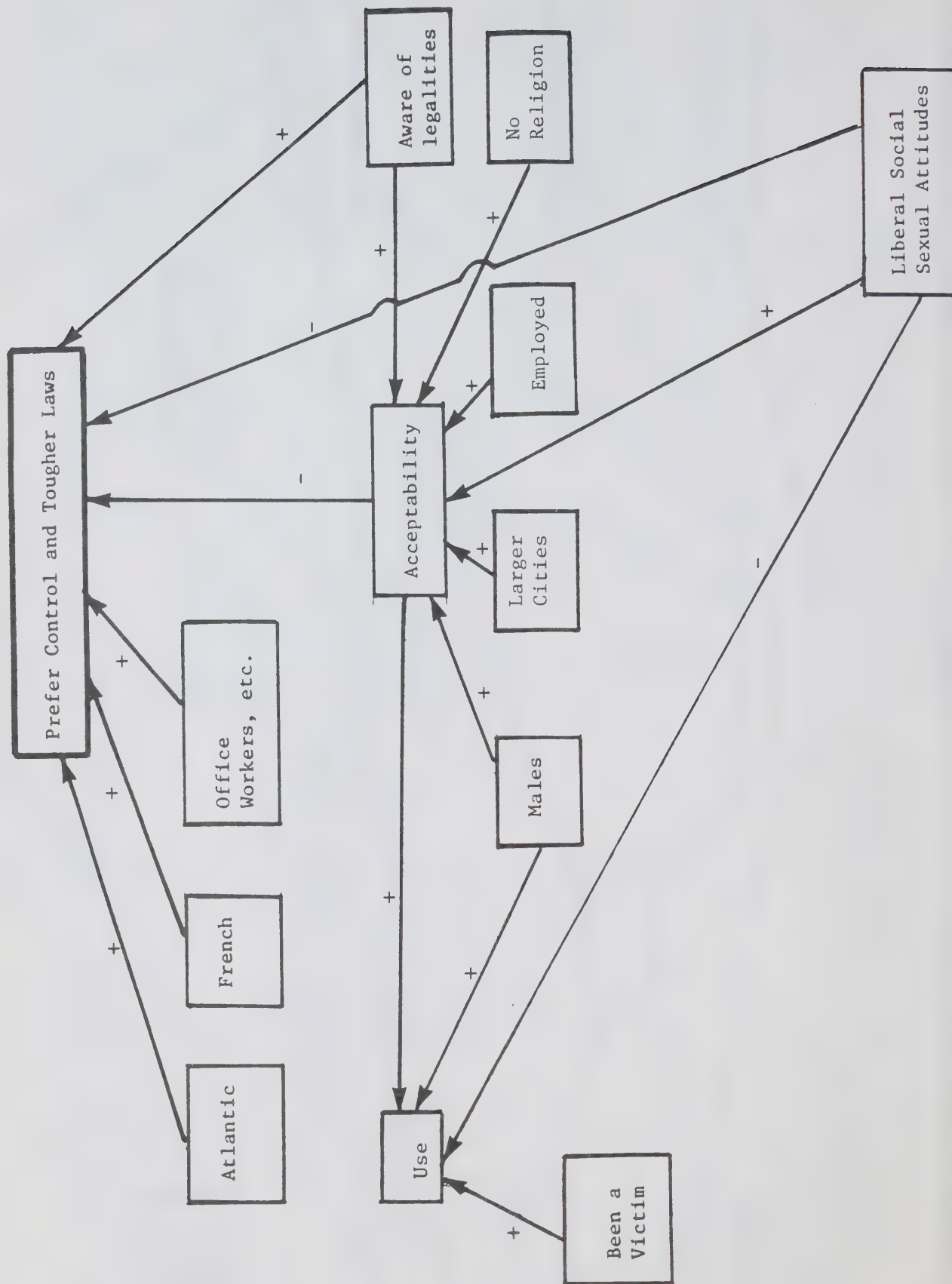


EXHIBIT 26

Relationship of Preference for more Control and Explanatory Variables





- those favouring more control and tougher laws tend to be French-speaking, from the Atlantic provinces, and in occupations like sales and services, or skilled, semi-skilled, and unskilled trades. They tend to find prostitution unacceptable, have conservative social sexual attitudes, and are more aware of the legalities related to prostitution
- those who have paid money in exchange for sex (users) tend to be males and consider this activity more acceptable. Users tend to have more conservative social sexual attitudes and to have been victims of sexual offenses
- individuals exposed to solicitation tend to be from larger cities, married, with a relatively high proportion in Ontario
- people who have wider levels of acceptability regarding prostitution tend to be males, from larger cities, employed, with no religious affiliation. They tend to be aware of the legalities of prostitution, and have more liberal social sexual attitudes
- it is also interesting to note that use does not affect preference for more control or legalization. Once attitudes on acceptability are controlled for, use has no significant explanatory power on policy options.



III - PORNOGRAPHY ISSUES

This chapter considers five issues related to pornography. Public concepts and perceptions about pornography are discussed first. This is followed by an elaboration of survey findings on use, exposure, legal knowledge and policy options. A final section provides a summary of the findings.

PUBLIC CONCEPTS ABOUT PORNOGRAPHY

The survey dealt with two major areas relating to public concepts about pornography:

- The first area dealt with levels of acceptability/offensiveness toward sexually explicit material. This area was examined first by assessing levels of acceptability towards very general statements about sexually explicit material. Then, the influence of the scene, audience and media on levels of acceptability was investigated. This was followed by an examination of the offensiveness associated with the availability of sexually explicit material near respondents' homes.
- The second area probed respondents' perceptions and beliefs about sexually explicit material. Respondents were asked to indicate the extent of their agreement on a number of allegations about the harms and benefits of pornography.

The definition of pornography was not explicitly examined in the survey because it was felt that the standards of acceptability and offensiveness towards pornography are very much related to what one defines as pornography. Instead, we focused on identifying where respondents draw the line between acceptable and offensive sexually explicit material.



LEVELS OF ACCEPTABILITY - GENERAL

There are wide-ranging levels of acceptance towards materials that have been labelled pornographic. There are some that express the view that all sexually explicit material is objectionable and unacceptable. Others express the view that not all sexually explicit material is unacceptable. The distinction often made by these individuals as to what is objectionable, is dependent on the circumstances surrounding the sexual representation (the mode in which it is conveyed, the context in which it appears and the audience to which it is communicated). Still others hold a much more liberal view and feel that everyone should have the individual freedom to consume, produce and distribute any material they want, as long as no one is harmed in the process.

The survey posed several questions which were intended to elicit the views of respondents regarding their standards of acceptability toward sexually explicit material.

Respondents were asked to indicate the extent of their agreement or disagreement to the following statements:

- all sexually explicit material for adult entertainment is obscene
- sex magazines are unacceptable in our society
- use of sexually explicit materials by adults is unacceptable
- everyone has the right to view sexually explicit material as long as it is done in private
- everyone has the right to produce sexually explicit materials so long as it does not hurt anyone.

The survey findings to this line of enquiry are shown in Exhibit 27, overleaf.

Exhibit 27

Level of Acceptability Towards Sexually Explicit Material

<u>Statement</u>	<u>Extent of Agreement</u>		
	<u>Agree</u>	<u>Neither</u>	<u>Disagree</u>
All sexually explicit material for adult entertainment is obscene	31%	23%	42%
Sex magazines are unacceptable in our society	45	18	35
Use of sexually explicit materials by adults is unacceptable	32	20	43
Everyone has the right to view sexually explicit material as long as it is done in private	66	15	16
Everyone has the right to produce sexually explicit materials so long as it does not hurt anyone	32	15	50



The standards of acceptability expressed by respondents reflect widely divergent views. A substantial number of respondents express the view that not all sexually explicit material is obscene (42%) while slightly fewer respondents (31%) indicate all such material is obscene. Many respondents have a fairly liberal opinion that individuals have the right to view sexually explicit material in private (66%). This liberal tendency is further reflected by 32% of the respondents who support everyone's right to produce sexually explicit material if it harms no one. Overall, respondents feel that individuals have a greater right to view sexually explicit material than producers have a right to produce sexually explicit material.

The use of sexually explicit material by adults is more acceptable to respondents (43%) than the very existence of sex magazines in our society (35%). In the first case, the audience is adult. In the second case the audience is society as a whole, thereby including adults and children. The inclusion of the latter group as a possible audience may account for the difference in the level of acceptability. The influence of the audience viewing sexually explicit material on level of acceptability is examined in depth later in the report.

Responses to these statements differed significantly by a number of socio-demographic-economic factors, as shown in Exhibit 28, overleaf. The most common factors are age and sex, where older people and females tend to have tighter levels of acceptability. Individuals without religion and those living in Quebec also show a somewhat wider level of acceptability in a number of these questions.

Level of Acceptability Towards Sex Magazines and Explanatory Variables

The influence of the socio-demographic-economic and other explanatory variables on acceptability of sex magazines was examined in our regression analysis. The results of the analysis and their interpretation are described in Exhibit 29, overleaf. Of the socio-demographic-economic variables, age and sex have the most significant relationship to the dependent variable. The other variables found to be significantly related are:

Exhibit 28

Levels of Acceptability: Significant Socio-Demographic-Economic Differences

<u>Statement</u>	<u>Variables</u>	<u>Significance Level</u>	<u>Agreement Direction</u>
All sexually explicit material for adult entertainment is obscene.	Age	.0000	Older people agree
	Sex	.0000	Females agree
	Religion	.0135	Catholics agree
Sex magazines are unacceptable in our society.	Age	.0000	Older people agree
	Sex	.0000	Females agree
Use of sexually explicit materials by adults is unacceptable	Age	.0000	Older people agree
	Sex	.0000	Females agree
	Religion	.0000	People without religion disagree
Everyone has the right to view sexually explicit material in private	Religion	.0005	People without religion agree
	Occupation	.0001	Skilled, semi-skilled and unskilled agree
	Quebec	.0011	Quebecers agree
	Income	.0022	Higher-incomes agree
	Age	.0241	Older people disagree
Everyone has the right to produce sexually explicit material so long as it does not hurt anyone	Quebec	.0000	Quebecers agree
	Sex	.0000	Males agree
	Schooling	.0000	Less educated agree
	Age	.0000	Older people disagree

Exhibit 29

Acceptability of Sex Magazines in our Society and Explanatory Variables

<u>Variable</u>	<u>T</u>	<u>Significance Level</u>	<u>Interpretation</u>
Age	4.797	.0000	Younger, acceptable
Sex	3.383	.0008	Males, acceptable
Social Sexual Attitudes	4.492	.0000	Those that do not think that the law should enforce sexual morals that agree with their own, acceptable
Social Sexual Attitudes	3.627	.0003	Those that agree that a person can do anything as long as it does not harm others, acceptable
Use	2.037	.0422	Those who read adult entertainment magazines, acceptable
Exposure	2.963	.0032	Those that are not aware of sexually explicit material showing children near their homes, acceptable
Social Sexual Attitudes	2.331	.0201	Those that agree a homosexual teacher is as acceptable as anyone else, acceptable
Use	1.832	.0676	Those who have bought adult entertainment magazines, acceptable



Social Sexual Attitudes: The importance of the relationship between social sexual attitudes and level of acceptability is shown in the model. Three variables representing these attitudes are significant - attitudes toward laws enforcing personal sexual morals, personal freedom to do things and homosexuals as teachers. We see that respondents with relatively liberal social sexual attitudes tend to have wider levels of acceptability toward sex magazines. Exhibit 30a, overleaf, illustrates the relationship between social sexual attitudes and acceptability. Fifty-nine percent of the respondents who believe that the law should enforce sexual morals that are compatible with their own morals, think that sex magazines are unacceptable compared to 36% of those who do not have this attitude.

Use: The relationship of use with acceptability is not surprising. More users of adult entertainment magazines find such material acceptable than non-users. Exhibit 30b, overleaf, illustrates the relationship of use and acceptability. Fifty-two percent of respondents who have read adult entertainment magazines find sex magazines acceptable versus 28% who have never read such magazines.

Exposure: Awareness of sexually explicit material showing scenes with children appears related to the level of acceptability. As shown in Exhibit 30c, those that are not aware of such material near their homes, more than others, feel that sex magazines are acceptable. Forty-one percent of respondents who are not aware of such material indicate sex magazines are acceptable compared to 29% who are aware of such material. Fifty-one percent of the respondents who are aware of such material indicate sex magazines are unacceptable.

LEVEL OF ACCEPTABILITY BY SCENE,
AUDIENCE AND MEDIA (CONJOINT ANALYSIS)

In this part of the analysis, we varied situations by scene, audience, and media, and elicited levels of acceptability for each situation. We then

Exhibit 30

Acceptability of Sex Magazines, Social Sexual Attitudes, Use and Exposure

<u>(a) Social Sexual Attitudes</u>		<u>(b) Use</u>		<u>(c) Exposure</u>	
To what extent do you agree or disagree that the law should enforce sexual morals which agree with your own?		How many adult entertainment magazines, if any, have you read or leafed through in the last 12 months?		Are magazines, videos, or movies showing sexually explicit scenes with children available near your home?	
Level of Acceptability		Neither		One or More	Yes
		Agree	Disagree		
To what extent do you agree or disagree that sex magazines are unacceptable in our society	Agree	199 58.9%	282 43.2%	720 52.9%	295 38.8%
	Neither Agree nor Disagree	41 12.0%	152 23.3%	233 17.1%	132 17.4%
	Disagree	92 27.4%	208 31.8%	325 51.9%	88 41.4%
	Missing	6 1.7%	11 1.7%	13 2.1%	5 2.5%
	Total	337 100.0%	654 100.0%	1362 100.0%	761 100.0%
To what extent do you agree or disagree that sex magazines are unacceptable in our society	Agree	199 58.9%	203 36.1%	166 26.6%	152 51.0%
	Neither Agree nor Disagree	41 12.0%	85 15.1%	122 19.4%	54 18.0%
	Disagree	92 27.4%	264 46.9%	378 27.9%	315 41.4%
	Missing	6 1.7%	11 2.0%	30 2.2%	19 2.5%
	Total	337 100.0%	563 100.0%	626 100.0%	299 100.0%



analyzed the data by the individual categories, and determined the extent to which the scene, audience and media affect the acceptability level. Results are shown in Exhibit 31, overleaf.

The first part of Exhibit examines the effect of scene on the respondents' level of acceptability. We see that sex combined with violence is the most unacceptable scene, followed by homosexual intercourse. These are considerably more unacceptable than one or more nude men and heterosexual intercourse. Finally, a scene of one or more nude women is clearly the most acceptable of the five scenes.

In examining the effect of audience, we see that there is little difference between viewing by oneself and viewing by other adults. However, there is a large difference between these two and an audience of children.

With regard to media effects, these are not large differences. A given scene and audience for television seems to be somewhat more acceptable than the same scene and audience for magazines and films.

If we look at significant effects within variables, we see that the major differences on effects are as follows:

- the differences between a scene of one or more nude women and a scene of sex combined with violence (a difference of 1.34)
- the difference between viewing by other adults and by children (1.20) and the differences between viewing by oneself and viewing by children (1.13).

Exhibit 31

Influence of Scene, Audience and Media
on Level of Acceptability

<u>VARIABLE</u>	<u>INFLUENCE ON ACCEPTABILITY*</u>
SCENE	
- One or More Nude Women	1.34
- Two Adults of the Same Sex Engaged in Sexual Intercourse	.39
- Sex Combined with Violence	.00
- A Man and a Woman Engaged in Sexual Intercourse	.99
- One or More Nude Men	1.08
AUDIENCE	
- Viewing Myself	1.13
- Viewing by Other Adults	1.20
- Viewing by Children	.00
MEDIA	
- Entertainment Shows on T.V.	.05
- Entertainment Magazines	.01
- Entertainment Films	.00

* Higher values indicate higher acceptability



A statistical analysis of the relative contribution of the three variables -- scene, audience, and media -- shows that audience (mainly explained by the children portion) is the most important explanation of acceptability, followed closely by scene. Media has little relative impact on acceptability.

Exhibit 32, overleaf, shows how overall acceptability for the situations presented differ by socio-demographic-economic characteristics. The major results are:

- older people generally find all situations less acceptable
- females find them less acceptable
- individuals in the Atlantic provinces, Manitoba, Saskatchewan, and British Columbia find the situations less acceptable than individuals in Quebec, Ontario and Alberta. Ontarians have the highest level of acceptability
- individuals who do not report a religion find them most acceptable. Protestants and those in a religion which is neither Protestant nor Catholic find the scenes least acceptable. Catholics are in the middle of these groups
- those with less than college education find the situations least acceptable
- the professional and technical occupational groups find them relatively less acceptable
- French language respondents find the situations generally more acceptable
- higher income individuals find them more acceptable
- those who are employed find the situations relatively less acceptable.

Exhibit 32

Relationship of Socio-Demographic-Economic Variables to
Levels of Acceptability of Given Situations

<u>Variable</u>	<u>T-Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
Age	14.22	.0000	Older, less acceptable
Sex	10.31	.0000	Males, more acceptable
Atlantic	6.43	.0000	Atlantic, less acceptable
Manitoba	5.17	.0000	Manitoba, less acceptable
Saskatchewan	7.61	.0000	Saskatchewan, less acceptable
Religion (none)	9.26	.0000	No religion, more acceptable
Religion (not Protestant or Catholic)	3.94	.0000	Religion neither Catholic nor Protestant, less acceptable
School 9-13	5.73	.0000	Schooling up to 9-13 years, less acceptable
Professional, administrator, and big business owner group	6.03	.0000	Professionals, less acceptable
French Language	6.96	.0000	French-speaking, more acceptable
Catholic	4.53	.0000	Catholics, more acceptable
Income	3.51	.0005	High income, more acceptable
Employed	2.98	.0030	Employed, less acceptable
School 0-8	3.08	.0021	Schooling up to 8 years, less acceptable
Ontario	2.47	.0134	Ontario, more acceptable
B.C.	1.97	.0491	B.C., less acceptable
Technical, small business owner, semi-professional group	1.69	.0916	Technical, small business owner, semi-professional, less acceptable



These different levels of scene, media, and audience can be combined to give an "acceptability index" labelled I. For example, the index for heterosexual intercourse for viewing on television by other adults is as follows:

$$I = .39 + 1.20 + .05 = 1.64$$

The least acceptable situations according to this index is sex with violence, viewed by children and shown in a film:

$$I = .00 + .00 + .00 = .00$$

The opposite end of this scale, i.e., the most acceptable situation, is a scene of one or more nude women, viewed by other adults on television:

$$I = 1.34 + 1.20 + .05 = 2.59$$

Exhibit 33, overleaf, shows all 45 situations, with the index scaled to be between 0 and 1. Thus the least acceptable situation (sex with violence, children in audience, and on film) has a standardized index of 0.00, and the most acceptable situation (nude women, with other adults to view, and on film) has a standardized index of 1.00. The cross-tabulations show that the least acceptable situation is acceptable to only 1% of respondents and the most acceptable situation is acceptable to 60% of respondents.

Based on an analysis of the cross-tabulations, the major socio-demographic-economic factors relating to the individual values assigned to the conjoint variables are sex and language. We thus ran separate conjoint models to investigate differences. The results are shown in Exhibit 34, overleaf. It is apparent in this Exhibit that the basic pattern of the conjoint models is very similar between sexes and language groups. In fact, there is only one major change between the sex models and one between the language models. Men rate a scene with one or more nude men less acceptable than heterosexual intercourse. This is reversed for women. A similar switch occurs with the French and English models. The French consider one or more nude men less acceptable than heterosexual intercourse, which is the reverse of the English.

Exhibit 33

Index of Acceptability

<u>SCENE</u>	<u>AUDIENCE</u>	<u>MEDIA</u>	<u>INDEX</u>
Nude Woman	Myself	T.V.	.97
		Magazines	.96
		Films	.95
	Other Adults	T.V.	1.00
		Magazines	.98
		Films	.98
	Children	T.V.	.54
		Magazines	.52
		Films	.52
Homosexual Intercourse	Myself	T.V.	.61
		Magazines	.59
		Films	.59
	Other Adults	T.V.	.63
		Magazines	.62
		Films	.61
	Children	T.V.	.17
		Magazines	.15
		Films	.15
Sex With Violence	Myself	T.V.	.46
		Magazines	.44
		Films	.44
	Other Adults	T.V.	.48
		Magazines	.47
		Films	.46
	Children	T.V.	.02
		Magazines	.00
		Films	.00
One or More Nude Men	Myself	T.V.	.87
		Magazines	.86
		Films	.85
	Other Adults	T.V.	.90
		Magazines	.88
		Films	.88
	Children	T.V.	.44
		Magazines	.42
		Films	.42
Heterosexual Intercourse	Myself	T.V.	.84
		Magazines	.82
		Films	.82
	Other Adults	T.V.	.86
		Magazines	.85
		Films	.85
	Children	T.V.	.40
		Magazines	.38
		Films	.38

Exhibit 34

Conjoint Models by Sex and Language

<u>VARIABLE</u>	<u>MALES</u>	<u>FEMALES</u>	<u>FRENCH</u>	<u>ENGLISH</u>
SCENE				
- One or more nude women	1.41	1.13	1.37	1.25
- Two Adults of the Same Sex Engaged in Sexual Intercourse	.48	.29	.44	.34
- Sex Combined with Violence	.00	.00	.00	.00
- One or More Nude Men	1.00	.98	.94	1.01
- A Man and a Woman Engaged in Sexual Intercourse	1.06	.79	1.03	.88
AUDIENCE				
- Viewing Myself	1.30	.90	1.06	1.08
- Viewing by Other Adults	1.28	1.13	.97	1.28
- Viewing by Children	.00	.00	.00	.00
MEDIA				
- T.V.	.02	.02	.08	-.004
- Magazines	.02	.03	.04	-.02
- Films	.00	.00	.00	.00



Level of Acceptability and Proximity

The tolerance of respondents toward the availability of sexually explicit material near their home was investigated. Respondents were asked whether they would be offended if they saw the following (in combination) kinds of sexual materials in a store near their homes:

- adult entertainment magazines, videos, or movies
- magazines, videos or movies showing sexually explicit scenes with violence
- magazines, videos or movies showing sexually explicit scenes with children.

Fifty percent of respondents indicate that they would be offended if they saw this material in a store near their homes. Another 15% indicate they would be offended if children were portrayed in such material and if such material were accessible to children. Thirty-two percent of respondents indicate they would not be offended.

In order to understand the influence of the socio-demographic-economic variables on the dependent variable, a regression model was developed. The final model indicates that there are five significant variables -- sex, age, marital status, education and religion -- which influence the level of offensiveness associated with sexually explicit material in a store near respondents' homes. The major results are:

- females more than males indicate they are offended by such material ($p = .0000$). Fifty-five percent of females versus 38% of males state that they would be offended
- older citizens more than young people are offended ($p = .0000$). The findings show that 60% of those 60 years and older are offended by such material whereas only 35% of respondents between 18-29 years of age are similarly offended



- married people are more offended than single people by these materials ($p = .0012$). Fifty percent of those who are married indicate that they are offended compared to 33% of singles
- those with less than 8 years of schooling are less offended than others ($p = .0055$)
- those of the Protestants religion are more offended than others by such material ($p = .0000$).

PERCEPTIONS AND BELIEFS ASSOCIATED WITH PORNOGRAPHY

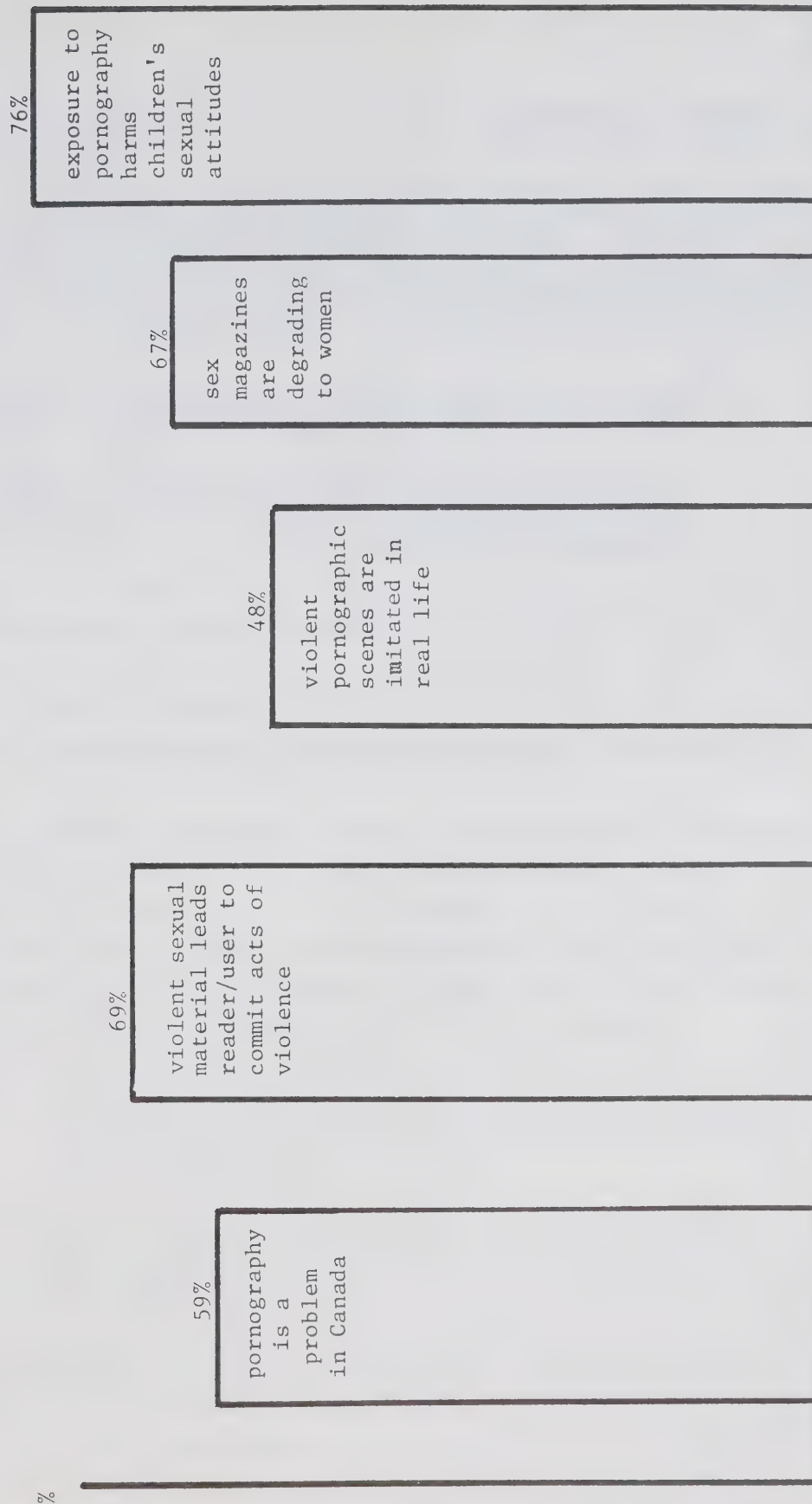
Pornography is felt to bring about a variety of harms, to society at large and to participants and consumers of pornography. In this respect, it is often argued that exposure to pornography leads to an increase in sexual and aggressive anti-social behaviour, that pornography is degrading to women, and that pornography has long-term effects on social values. The potential impact of pornography on children is of particular concern since it is argued their vulnerability is greater because they do not have stable attitudes towards human sexuality.

There is also some argument that pornography performs a number of socially desirable functions by providing an outlet for potentially aggressive sexual tendencies and by reducing misunderstandings about sex and sexual practices.

In order to obtain the respondents' views about these harms (or benefits), they were asked to state the degree to which they agreed or disagreed with a series of statements about pornography. The findings are discussed in terms of who allegedly is harmed by or benefits from pornography. The findings are discussed below, and summarized in Table 6, overleaf. As can be observed, the prevalent thinking is that pornography has harmful effects.

TABLE 6

HARMS OF PORNOGRAPHY



ALLEGED HARMS OF PORNOGRAPHY



Harm to Society - in General

The degree to which respondents feel pornography is a problem in Canada was probed in the survey. Fifty-nine percent of respondents feel that pornography is a problem in Canada, while 26% are of the opposite opinion. The following relationships to the socio-demographic-economic variables are revealed:

- more females than males feel pornography is a problem (67% versus 50%), significant at $p = .0000$
- respondents in the professional occupational group feel that pornography is a problem more than the other occupational groups ($p = .0000$).

When directly asked, respondents show a strong belief that pornography is a problem in Canada. However, this must be tempered with the responses to a general survey question on the major social problems in Canada which reveals that only 1% of respondents feel pornography is a major social problem.

The discrepancy in the responses to these two questions may be attributed to a number of causes. The more general question (i.e., what is the major social problem) was asked at the beginning of the survey interview, while the more specific question (i.e., pornography is not a problem) was asked later on in the interview process. The other questions concerning pornography may have influenced respondents' answers. The more likely interpretation, however, is that many respondents feel pornography is indeed a problem in Canada, but not as important as other social problems.*

* The question of whether pornography is a problem was asked in a preliminary study conducted earlier this year (February 1984) for the Department of Justice. Respondents were asked whether they thought pornography was a social problem. Pornography was "not a problem at all" for 36% of the respondents, while 56% thought it was a problem to some degree. The findings of the present survey are corroborated by the February 1984 survey. The concern that pornography is a problem has not significantly changed since the earlier study.



Harm to Society - Increase in Violent Crimes and Anti-Social Behaviour

It is argued that exposure to pornography leads to criminal or anti-social behaviour. Pornographic material is thought to arouse sexual desire which, if not satisfied by normal sexual activity, becomes transposed into aggressive acts. As well, it is maintained that the aggressive acts will emulate the sexual behaviour portrayed in pornography. Evidence that is available has not conclusively proved or disproved the relationship between the viewing of pornography and criminal or anti-social behaviour.

The survey probed respondents' views on the relationship of pornography and the commission of such crimes. Two statements which concerned the influence of pornography on acts of violence and anti-social behaviour were presented to respondents:

- violent sexual material leads readers or viewers to commit acts of violence
- violent pornographic scenes are imitated by people in real life.

Strong support exists for both statements; however, respondents are more inclined to believe that violent sexual material leads to the commission of acts of violence than to the imitation of acts of violence:

- 69% of respondents agree that violent sexual material leads the reader or viewer to commit acts of violence and 17% disagree
- 48% of respondents agree that violent pornographic scenes are imitated by people in real life and 24% disagree.

Exhibit 35, overleaf, shows how opinions differ about the effect of sexually explicit material on violent behaviour by the socio-demographic-economic variables. The most common factors are language and sex. We see that females

Relationship of Socio-Demographic-Economic
Variables on Views Regarding
the Effects of Sexually-Explicit Material

(a) Effect on Commission of Acts of Violence

<u>Variable</u>	<u>T Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
Sex	7.227	.0000	Females more than males agree material has effect on commission of acts of violence
Age	3.965	.0000	Older, agree material has effect on commission of acts of violence
Marital Status	2.460	.0135	Married, agree material has effect on acts of violence
Language	1.975	.0485	Francophones, more than Anglophones, agree material has effect on acts of violence

(b) Effect on Imitation of Acts of Violence

<u>Variable</u>	<u>T Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
Language	7.865	.0000	Anglophones, more than Francophones, agree material has effect on imitation of acts of violence
Sex	3.900	.0000	Females more than males, agree material has effect on imitation of acts of violence
Education	2.264	.0238	Schooling less than 8 years, agree material has effect on imitation of acts of violence
Occupation	1.733	.0835	Professional, big business owner, and administrator occupation group, agree material has effect on imitation of acts of violence



tend to agree this material has harmful effects on behaviour. For example, the figures in the survey showed that 39% of females and 27% of males agree that violent sexual material has an effect on the commission of acts of violence. With respect to language we see an interesting shift. Francophones more than Anglophones support the view that this material leads to the commission of acts of violence, yet the converse is true in relation to the influence of the material on the imitation of acts of violence.

Harm to Society - Degradation of Women

There is a concern voiced by some groups that pornography is hostile to women, portraying them in a negative manner (e.g., as subservient to men, as enjoying a variety of violent activities, etc.). The negative manner in which women are portrayed in pornography is alleged to diminish the status and dignity of women.

The concerns regarding the degradation of women in pornographic material were investigated in the survey. Respondents were asked to indicate the extent of their agreement with the statements:

- sex magazines are degrading to women
- women are portrayed in a more degrading fashion than men in sexually explicit material
- pornography is degrading to men.

Respondents elicited a substantial amount of agreement in regard to the first two statements. Sixty-seven percent of respondents indicate that women are portrayed in a degrading fashion and 21% indicate the contrary. In regard to the portrayal of women in a more degrading fashion than men, 66% of respondents indicate agreement with the statement and 15% disagree. The modelling results of these questions reveal that age and sex are by far the most important influences on responses (significant at $p = .0000$ in both cases). For example



76% of females find sex magazines degrading to women, as opposed to 57% of men. Eighty-one percent of those over 60 years of age find sex magazines degrading to women; this compares with 60% for those under 30 and 59% for those between 30 and 44.

While a number of respondents feel that sex magazines are degrading to women and more so than to men, there are those who feel pornography is degrading to men. In response to the question asking respondents to indicate whether they feel pornography is degrading to men, 38% answer in agreement and 30% in disagreement.

Harm to Children

There is a concern that individual consumers of pornography may suffer harm. The influence of pornography on children is felt to be particularly important because it is argued that they have not developed stable attitudes towards human sexuality. Exposure to scenes depicted in pornographic material is felt to be detrimental to the proper development of children. As well, the environment often associated with the selling of pornographic material is felt to be unhealthy for children.

The belief that children may suffer harm as a result of exposure to pornography was strongly upheld by survey respondents. Most respondents (76%) feel that exposure to pornography cannot help children develop healthy sexual attitudes. Most respondents also feel that the environment associated with the selling of pornographic material was bad for children. Seventy-eight percent of respondents agree that the availability of sex magazines in areas frequented by children is bad for them.

Respondents were asked to what extent they agreed with the statement "sexually explicit material showing children is unacceptable in our society". Overall, only 4% of the respondents disagree with this statement, i.e., the great majority of adult Canadians find such material unacceptable.



There are some variations in the strength of this belief, however. The significant differences are shown below:

- individuals in Ontario find sexually explicit material less acceptable than others ($p = .0000$). For example, in Ontario, 94% of the respondents strongly agree with the statement, compared to, for example, 76% in Quebec and 85% in the Atlantic Provinces
- schooling, where less educated people find sexually explicit material with children more acceptable than others. The relationship for respondents with less than 8 years of schooling is significant at $p = .0001$ and for respondents with 9-13 years of schooling, it is significant at $p = .0067$. The cross-tabulations show that 98% of those with over grade 13 education find it unacceptable, compared to about 92% of those with up to grade 13. The percentage differences are not large because the influence of age is confounding the influence of schooling. Age and schooling are related to each other. Those with less schooling are relatively older individuals
- age is also important, with older people finding such material less acceptable. This relationship is significant at $p = .0032$. The cross-tabulations do not show large differences because the influence of age is being confounded by the influence of schooling. As described above, schooling and age are strongly related to each other
- community size has a relationship with the belief about sexually explicit material showing children, although it is not highly significant ($p = .1630$). Respondents in larger communities find such material more acceptable than others.

The relationship of the socio-demographic-economic influences on the acceptability of sexually explicit material showing children is discussed in more depth in Chapter I and shown in Exhibit 1.



Benefits of Pornography

It has been argued that pornography has a number of beneficial attributes. For instance, some state that pornography provides an outlet for what may be potentially aggressive sexual tendencies. As well, some state that pornography enables sex to be brought out into the open, thereby minimizing misunderstanding about it and promoting healthier sexual relations.

The views of respondents concerning these beneficial or desirable aspects of pornography were examined. With respect to the function of pornography as an alternative to potentially aggressive behaviour:

- 44% of respondents do not feel that sexually explicit material can be a safe outlet for aggressive sexual behaviour, 25% feel that it can be a safe outlet and 26% do not express an opinion either way.

Respondents are less decisive about the contribution of sexually explicit material to pleasurable sexual experiences:

- 32% of respondents feel that sexually explicit material could have this function, 30% disagree and 32% did not express an opinion either way.

USE PATTERNS - ADULT ENTERTAINMENT MATERIAL

Survey respondents were asked to describe their use of adult entertainment material. The type of media (magazines, television, videos) used, the material portrayed and the frequency of the material's consumption were investigated. Use patterns are described by media type.



MAGAZINES

A large number of respondents (89%) report never having bought adult entertainment magazines in the last 12 months.* Our analysis found that the purchasing of adult entertainment magazines differs by a number of the socio-demographic-economic variables. The significant variables are sex, education and employment status:

- males buy more of these magazines than females
 $p = .0000$). Of the 10% who had bought such magazines, 15% were males and 5% were females
- respondents with an education level less than 8 years
buy fewer of these magazines than others ($p = .0372$)
- employed individuals are less inclined to buy these
magazines than others ($p = .0479$).

Other relationships found, although not statistically significant, are:

- consumers of such magazines tend to be from Ontario and the West more than from Quebec or the Atlantic
- singles more than married people have bought such magazines (82% versus 91%)
- young people buy these magazines more than older citizens.

* A preliminary survey conducted in February 1984 for the Department of Justice found an identical use pattern for magazines. Eighty-nine percent of respondents reported never having bought magazines depicting scenes of a sexual nature in the last twelve months.



While the number of respondents who have bought adult entertainment magazines is quite low, there is a much higher proportion of respondents who have read or leafed through such magazines in the last twelve months. In the latter case, 67% have never read or leafed through such magazines and 32% have done so one or more times. Those that have read or leafed through adult entertainment magazines have similar sex, age, income, education and marital status characteristics to those that buy these magazines. We see a shift in that employed respondents are less inclined to buy these magazines, yet are more inclined to read or leaf through them than are unemployed respondents. The most significant socio-demographic-economic differences are as follows:

- males read or leaf through adult entertainment magazines more than females (p = .0000)
- older citizens read or leaf through these magazines less than younger people (p = .0000)
- employed respondents read or leaf through these magazines more than others (p = .0866).

Type of Magazines

Of the magazines purchased by respondents, Penthouse is bought by 39%, Playboy by 30%, Playgirl by 8% and Hustler by 6%. Magazines such as Lui, Hustler and others are bought by another 7% of respondents. The sex breakdown shows that a greater percentage of females (36%) have purchased Playboy than males (28%).

The magazines that are being bought are the same as those that are being read or leafed through, although in different proportions. Playboy is read or leafed through by 38% of respondents, Penthouse by 23%, Hustler by 7%, Playgirl by 6% and other magazines by 7%. While Penthouse is the magazine most frequently bought, Playboy is most frequently read or leafed through.



Scenes in Magazines

Respondents were asked to indicate the frequency with which they had seen five scenes in entertainment magazines. The scenes presented to respondents were:

- one or more nude women
- two adults of the same sex engaged in sexual intercourse
- sex combined with violence
- one or more nude men
- a man and a woman engaged in sexual intercourse.

The scene observed most frequently in the magazines is one or more nude women. Forty-seven percent of respondents indicate they have observed such a scene in a magazine. The next most frequent situation is one or more nude men, with 31% of respondents having seen this in an entertainment magazine. This is followed by 28% of respondents who have seen a man and woman engaged in sexual intercourse, 20% who have seen two adults of the same sex engaged in sexual intercourse, and 13% who have seen sex combined with violence in magazines. Some of the activities portrayed in these scenes may have been implied rather than explicit; however, this could not be determined from the survey.

It appears from the type of magazines being bought or read and the scene being portrayed, that most respondents are consuming magazines which are generally categorized as soft core.

VIDEO CASSETTES

Usage patterns for video cassettes are similar to those found for magazines. Eighty-eight percent of respondents have not bought or rented adult-only video



cassettes in the last twelve months and 11% have never done so.* Respondents who have purchased or rented video cassettes tend to be younger people. Age is the only significant socio-demographic-economic variable influencing the usage of video cassettes (p = .0000). As seen in Exhibit 36, overleaf, 98% of those over 60 have not bought or rented video cassettes in the last 12 months, compared to 82% for the 18-29 age bracket and 80% for the 30-44 age bracket.

Type of Films

The survey did not specifically consider video cassette films, but examined the frequency of viewing entertainment films in general. Thus, the type of material being viewed on film may have been seen on video cassettes or in movie theatres.

The survey investigated the type of film material being viewed by respondents by asking them to describe the frequency with which they viewed specific scenes in entertainment films. The scenes were the same as those described above for entertainment magazines.

Scenes showing one or more nude women are viewed by 43% of respondents, followed in frequency by scenes showing a man and a woman engaged in sexual intercourse (38%) one or more nude men (34%), two adults of the same sex engaged in sexual intercourse (20%) and sex combined with violence (18%).

As in the case of magazines, the degree to which the activities shown in the films were explicit or implicit could not be determined from the survey.

TELEVISION SHOWS

Television, more than magazines and video cassettes, is the medium where most respondents view adult entertainment (see Table 7, overleaf). Fifty-seven

* The preliminary survey conducted in February 1984 for the Department of Justice found similar use patterns for videos. Eight-two percent of respondents have never seen videos depicting scenes of a sexual nature.

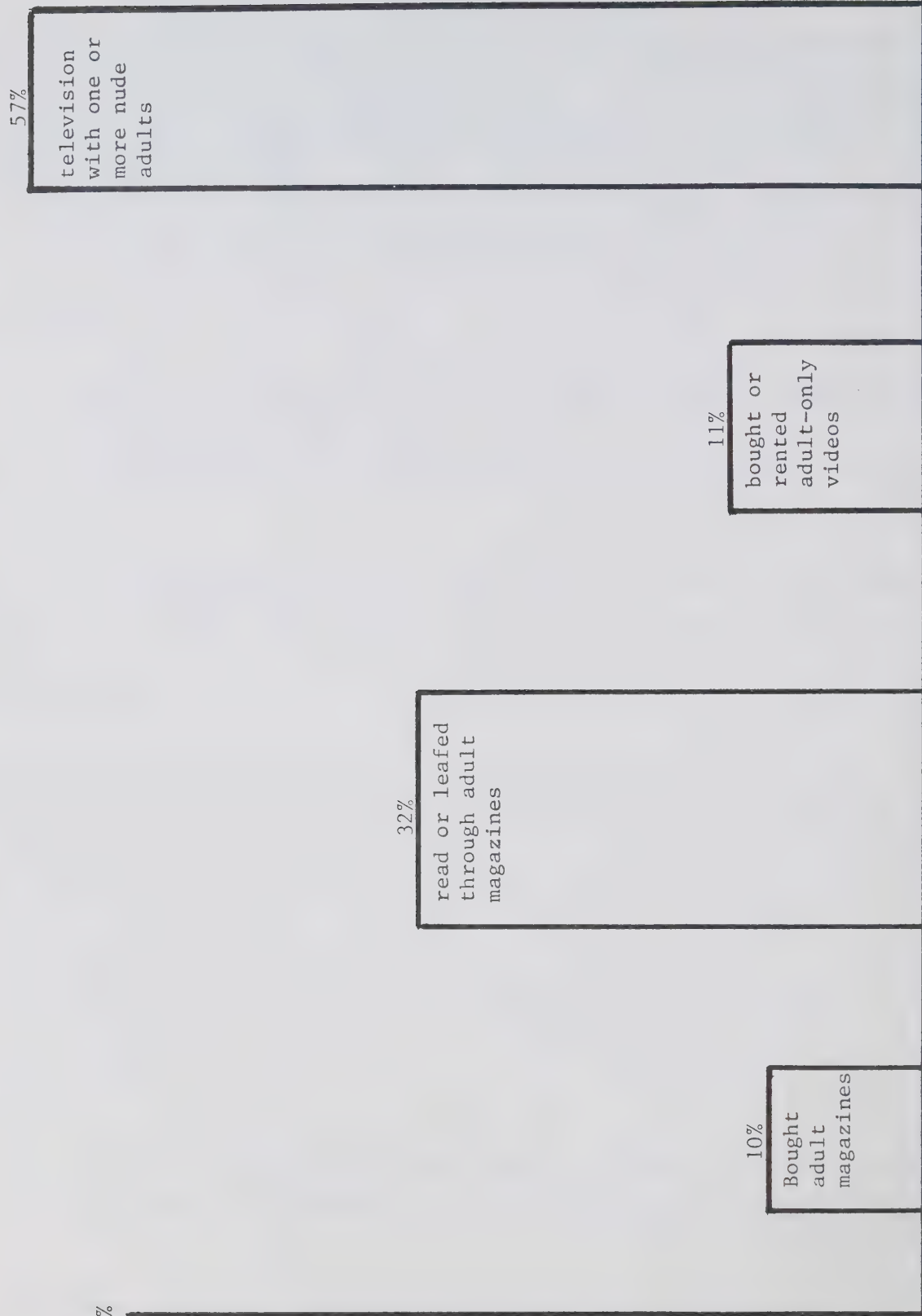
EXHIBIT 36

Buying or Renting Adult-Only
Video Cassettes in Last 12 Months by Age

<u>Frequency</u>	<u>Age</u>			
	<u>18-29</u>	<u>30-44</u>	<u>45-59</u>	<u>60+</u>
None	82%	84%	92%	98%
One	4	5	2	0
2-5	10	7	2	0
Over 5	4	3	2	0
No answer	0	1	2	2

TABLE 7

AT LEAST ONE USE OF ADULT ENTERTAINMENT IN THE LAST 12 MONTHS



ADULT ENTERTAINMENT MATERIAL



percent of respondents state that they have seen adult entertainment programs on television showing nude adults in the last 12 months (41% indicate they have not). Viewers of these adult entertainment programs have the following characteristics:

- British Columbia residents view these television programs the most (an average of over 9 times in the last 12 months). This is significantly different than other provinces at a level $p = .0039$
- respondents in large communities view these programs less often than small communities, (an average of 6.5 times in small communities compared to 5.2 times in large communities). This is significant at $p = .0513$.
- single individuals view these programs more often than married people, (an average of 6.8 times for singles compared to 5.2 times for married respondents). This is significant at $p = .0340$.
- Francophones, more than Anglophones, view adult entertainment programs (7.6 times in 12 months for the French compared to 4.8 times for the English), but this is not statistically significant
- a somewhat larger frequency by those in the skilled, semi-skilled, and unskilled occupational group is revealed (5.8 as an average compared to, for example, 5.3 by homemakers), but this is not statistically significant.

Type of Television Programs

Respondents were asked the frequency with which they had seen specific scenes on television in the past 12 months. The scenes were the same as those described for magazines and films.

Television programs showing scenes with one or more nude women were most frequently seen (52%), followed by scenes showing a man and woman engaged in sexual intercourse (38%), one or more nude men (32%), sex combined with violence (32%) and two adults of the same sex engaged in sexual intercourse (17%).



The extent to which the activities described in some of these scenes were explicit or implicit or, the actual content and nature of the activities could not be determined from the survey.

TYPE OF MATERIAL USED BY MEDIA: A COMPARISON

Exhibit 37, overleaf, consolidates the findings of the survey with respect to each media by the type of material being viewed. In comparing the type of material being viewed in each of the different media, the following patterns emerge:

- A scene showing one or more nude women is the scene most frequently being viewed, regardless of medium. This scene is more frequently being viewed on television and magazines than on films.
- The next most frequently viewed scene is a man and a woman engaged in sexual intercourse. This scene is more frequently viewed on television and film than in magazines.
- A scene showing one or more nude men is the next most frequently viewed, and it is seen in fairly equal proportions on all three media.
- Scenes showing two adults engaged in homosexual intercourse and sex combined with violence are the least viewed by respondents. Scenes showing adults engaged in homosexual intercourse are seen in fairly equal proportions on all three media. Sex combined with violence is seen more often on television and film than in magazines.

Although there are some switches among media as to where these scenes are being viewed, the pattern of responses indicates that one or more nude women and a man and woman engaged in sexual intercourse are most frequently being viewed. This is followed in frequency by scenes showing one or more nude men, homosexual intercourse and sex combined with violence. This relates directly to the level of acceptability held towards these scenes (see conjoint

EXHIBIT 37

Frequency of Viewing Sexually
Explicit Material By Media

<u>Media</u>	<u>Frequency</u>	<u>One or</u>	<u>One or</u>	<u>Two Adults</u>	<u>Sex</u>	<u>A Man and</u>
		<u>More Nude</u>	<u>More Nude</u>	<u>of Same Sex</u>	<u>Combined</u>	<u>Women Engaged</u>
		<u>Women</u>	<u>Men</u>	<u>Engaged in</u>	<u>with</u>	<u>in Sexual</u>
				<u>Sexual Inter-</u>	<u>Violence</u>	<u>Intercourse</u>
				<u>course</u>		
Magazines	None	36%	51%	63%	68%	54%
	Once	5	7	5	4	5
	2-5	19	16	9	7	14
	Over 5	23	8	6	2	9
	Missing	17	17	17	17	18
Films	None	37%	46%	60%	61%	42%
	Once	5	10	6	6	7
	2-5	21	16	10	9	18
	Over 5	16	8	4	3	12
	Missing	19	20	19	20	20
Television	None	31%	50%	67%	57%	43%
	Once	5	8	6	8	7
	2-5	22	16	9	16	16
	Over 5	25	8	2	8	15
	Missing	17	17	16	17	17



analysis). Thus, the most acceptable scenes (e.g., one or more nude women) are most frequently viewed and the least acceptable scenes (e.g., sex combined with violence) are least viewed.

USE OF ADULT ENTERTAINMENT MAGAZINES, VIDEOS AND/OR TELEVISION

We analyzed the use of adult entertainment magazines, videos and television by respondents in order to determine whether they use these three media alone or in combination. The results of this analysis are depicted in Exhibit 38, overleaf. As may be observed most respondents (31%) view adult entertainment on television only. Six percent of respondents view adult entertainment on all three media. Nearly a third of the respondents (32%) never consume adult entertainment on any of the three media.

CONSUMPTION OF ADULT ENTERTAINMENT MAGAZINES, VIDEOS AND TELEVISION AND EXPLANATORY VARIABLES

In order to understand the differences in responses to the use of adult entertainment material, regression models were built for three dependent variables:

- reading adult entertainment magazines
- buying or renting adult entertainment video cassettes
- watching programs with nude adults on television.

The modelling results are described and interpreted in Exhibit 39, overleaf. The most common explanatory variable influencing the use of all media is public concepts or the level of acceptability toward sexually explicit material. Respondents who have a tolerant attitude toward various forms of sexually explicit material tend to consume relatively more adult entertainment material.

EXHIBIT 38

Use of Adult Entertainment Magazines,
Videos, and/or Television

<u>Material Used</u>	<u>Number</u>	<u>Percentage</u>
None	636	31.5%
Magazines only	137	6.8
Videos only	25	1.2
Television only	617	30.6
Videos & Magazines	28	1.4
Videos & Television	61	3.0
Magazines & Television	337	16.7
Videos, Magazines & Television	115	5.7
No Answer	<u>62</u>	<u>3.1</u>
Total	2,018	100.0%

Relationship of Reading Adult Entertainment Magazines, Buying or Renting Adult
Entertainment Videos and Watching Programs with Nude Adults
on Television and Explanatory Variables

<u>Variable</u>	<u>T-Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
<u>MAGAZINES</u>			
Public Concepts	3.064	.0023	Those that find magazines available with nude women unacceptable, tend not to read adult entertainment magazines.
Sex	3.407	.0007	Males tend to read more than females.
Public Concepts	2.797	.0053	Those that find magazines showing homosexual sexual intercourse unacceptable, tend not to read.
Public Concepts	2.562	.0107	Those that consider it important whether material is for entertainment versus art or education, tend to read.
Public Concepts	1.839	.0664	Those that are not offended by adult entertainment material (including that showing violence and scenes with children), tend to read.
Public Concepts	1.831	.0677	Those that agree that sex magazines are acceptable, tend to read.
<u>VIDEOS</u>			
Public Concepts	1.856	.0640	Those that disagree sex magazines are degrading to women tend to buy/rent videos .
Exposure	2.540	.0113	Those that can easily find or see video cassettes featuring sexual acts between adults in the area where they live, tend to buy/rent.
Exposure	2.073	.0386	Those that are not aware of magazines, videos, or movies showing sexually explicit scenes with children, tend to buy/rent.
Public Concepts	2.529	.0117	Those that think sexually explicit material showing children is acceptable, tend to buy/rent.
Public Concepts	1.927	.0545	Those that find magazines available with nude women unacceptable, tend not to buy/rent.
Public Concepts	1.862	.0631	Those that agree that violent sexual material leads readers to commit acts of violence, tend to buy/rent.
<u>TELEVISION</u>			
Exposure	3.845	.0001	Those that can easily find or see T.V. movies showing nude adults, tend to have watched programs showing nude adults on T.V.
Public Concepts	2.466	.0139	Those that find it acceptable to watch heterosexual intercourse on late night T.V., tend to watch.
Exposure	2.227	.0264	Individuals who were older when they first saw a nude adult, do not tend to watch.
British Columbia	2.006	.0453	British Columbia residents tend to watch programs with nude adults on T.V., more than others.
Social Sexual	2.000	.0460	Those that disagree that a woman must have higher sexual morals than a man, tend



Awareness of the existence of adult entertainment material near one's home (exposure) is the next most common explanatory variable influencing use. Respondents that can easily find or see video cassettes (featuring sexual acts between adults) or television movies (showing nude adults) in the area where they live, tend to consume this material relatively more than others. We also see that exposure to a nude adult at an earlier age is related to a more frequent use of adult entertainment on television.

The relationship of viewing programs with nude adults on television and the two explanatory variables (i.e., public concepts and exposure) is illustrated in Exhibit 40, overleaf. The cross-tabulation shown in Part a of the Exhibit clearly demonstrates that respondents who find sexual intercourse between a man and a woman acceptable are more frequent viewers of programs with nude adults than those who find it unacceptable (72% versus 44%). The cross-tabulation shown in Part b of the Exhibit presents a similar relationship with exposure. Respondents who can easily see television movies showing nude adults in the area where they live are relatively more frequent viewers of such movies than those that cannot easily see such movies (72% versus 43%).

DEGREE OF EXPOSURE TO SEXUALLY EXPLICIT MATERIAL

The degree of exposure to sexually explicit material was explored with respondents in three ways. The first dealt specifically with respondents' awareness of different types of sexually explicit material near their homes. Then, we focussed on obtaining respondents' perceptions about the availability and accessibility of pornographic material. Finally, we assessed exposure by examining the age of first exposure to pictorial nudity and actual nudity.

AWARENESS OF SEXUALLY EXPLICIT MATERIAL NEAR ONE'S HOME

The degree of exposure to sexually explicit material was examined by focussing on the respondents' awareness of this material near their homes. We could not determine from the survey responses whether such material is available and

EXHIBIT 40

Relationship of Viewing Programs with Nude
Adults on T.V. with Public Concepts and Exposure

	(a) <u>Public Concepts</u>		(b) <u>Exposure</u>	
	How acceptable do you find sexual intercourse between a man and a woman, as shown on late-night T.V.?	Could you easily find or see the T.V. movies showing nude adults in the area where you live?		
	<u>Unacceptable</u>	<u>Acceptable</u>	<u>No</u>	<u>Yes</u>
How often, if ever have you seen entertainment programs on T.V. showing nude adults in the last twelve months?				
Never	568 54.4%	238 26.2%	210 56.0%	233 25.4%
One or more times	457 43.8%	657 72.2%	160 42.7%	663 72.2%
Missing	19 1.8%	15 1.3%	5 1.3%	22 2.4%
Total	<u>1,044</u> 100.0%	<u>911</u> 100.0%	<u>376</u> 100.0%	<u>918</u> 100.0%



respondents are not aware of its existence, nor could we determine what boundaries respondents gave to the term "near your home". Awareness of the availability of the following types of material was assessed:

- adult entertainment magazines, videos, or movies
- magazines, videos or movies showing sexual explicit scenes with violence
- magazines, videos or movies showing sexually explicit scenes with children.

Overall, respondents were most aware of the availability of a general type of adult entertainment material near their homes. They had less knowledge of such material showing scenes with violence and much less knowledge of such material showing scenes with children. The overall results are shown in Table 8, overleaf.

Adult entertainment magazines, videos or movies are known to be available by 73% of respondents. Twelve percent indicate that such material is unavailable and 14% are not certain of its availability. The relationships to the socio-demographic-economic variables are shown in Exhibit 41, overleaf and described below:

- younger people have more knowledge of such material than older citizens ($p = .0000$)
- higher income earners know about the availability of such material more than low income earners ($p = .0001$)
- respondents in the Atlantic are least aware of this material ($p = .0003$)
- Francophones are more aware of such material than Anglophones ($p = .0031$)

TABLE 8

AVAILABILITY OF SEXUALLY EXPLICIT MATERIAL

%

73%

adult entertainment
magazines, videos
or movies

43%

sexually
explicit
scenes
with
violence

15%

sexually explicit
scenes with
children

TYPE OF MATERIAL

EXHIBIT 41

Awareness of Adult Entertainment
Magazines, Videos or Movies Near One's Home

	<u>Aware</u>	<u>Unaware</u>
AGE		
18-29	90%	6%
30-44	82	9
45-59	66	13
60+	42	24
INCOME		
Under 15K	58%	24%
15K-24K	68	17
25K-34K	76	13
35K+	85	11
PROVINCE		
B.C.	82%	8%
Alberta	74	12
Saskatchewan/Manitoba	69	13
Ontario	69	13
Quebec	77	11
Atlantic	65	16
EDUCATION		
0-8	47%	22%
9-13	76	11
14+	81	8
MARITAL STATUS		
Married	71%	13%
Single	85	7
COMMUNITY SIZE		
Over 1,000,000	76%	10%
100,000 - 999,999	66	16
50 - 99,999	75	7
Under 5000	74	13
OCCUPATION		
Homemaker	65%	13%
Professional	85	6
Technical	86	8
Office/Sales	81	9
Skilled, semi-skilled, unskilled	75	11
LANGUAGE		
French	74%	13%
English	72	12



- education has an influence on the extent of knowledge about the availability of such material. Only 43% of those with 0-8 years of education know about the availability of these material while 81% of those with 14 or more years have this knowledge ($p = .0003$)
- 71% of married respondents versus 85% of single respondents know about the availability of such material, but this appears to be due mainly to age (singles are younger)
- those residing in a community with 100,000 - 999,999 population are less knowledgeable about such material than those in much larger and smaller communities (66% versus about 75% in other communities)
- homemakers indicated the least knowledge about the availability of such material (although this again is linked to age and income, so is not statistically significant).

This information is summarized in Exhibit 42, overleaf.

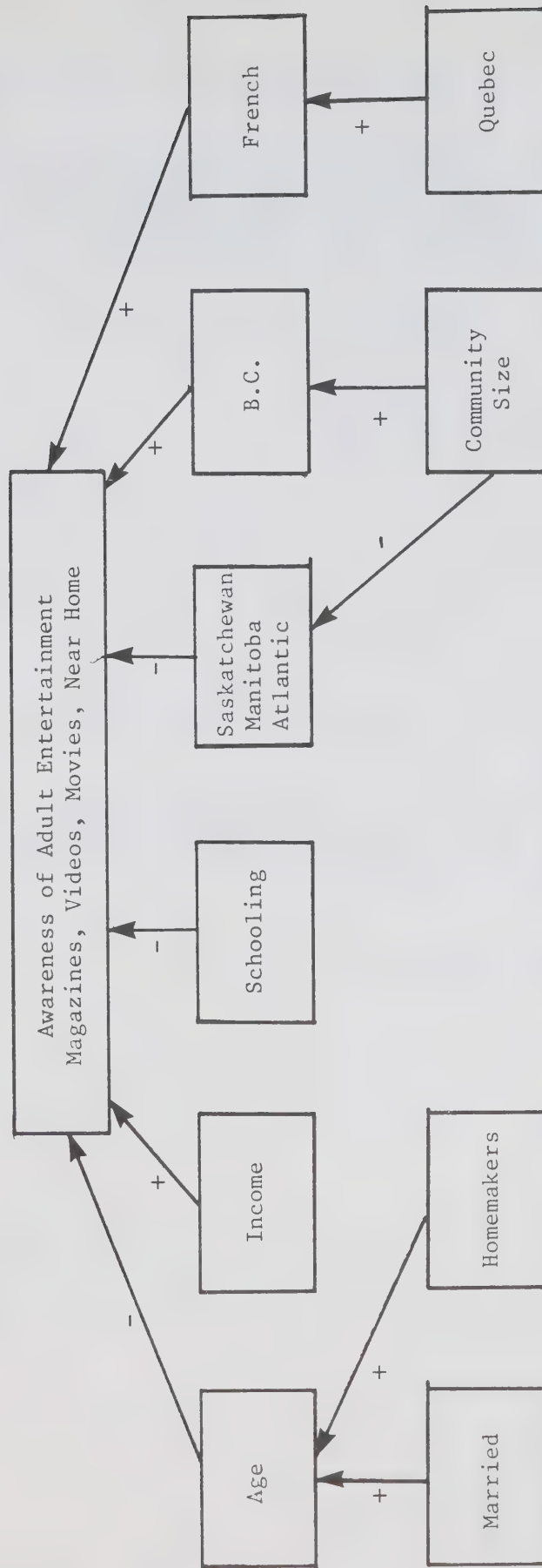
Material showing sexually explicit scenes with violence is known to be available to 43% of respondents. Such material is known to be unavailable by 23% of respondents and 33% are not certain of its availability. A similar relationship is found with the socio-demographic variables as in the case above.

Material showing sexually explicit scenes with children is known to be available to only 15% of respondents. Most respondents indicate that such material is unavailable near their homes (38%) or that they do not know whether it is available (46%). A significant link is found with language and the knowledge of the availability of such sexually explicit material ($p = .0078$). More Francophones know about such material than Anglophones (18% versus 13%). There are other links (although not significant) found with geographic area of residence and community size:

EXHIBIT 42

EFFECT OF SOCIO-DEMOGRAPHIC - ECONOMIC

VARIABLES ON EXPOSURE TO PORNOGRAPHY





- residents of B.C. are most aware (24%) of the existence of this material near their homes, followed by residents of Quebec (19%), Ontario (13%), Manitoba and Saskatchewan (13%), Alberta (11%) and the Atlantic (10%)
- residents of small communities are least aware of such material.

AVAILABILITY OF PORNOGRAPHY

The perceptions of respondents about the availability and accessibility of pornographic material were obtained in the survey by asking them to indicate the extent to which they agreed or disagreed with the statements below:

- pornography is easily available to everyone
- pornography can be easily seen on television.

Most respondents (74%) consider pornography to be easily available to everyone. Forty-eight percent feel pornography can be easily seen on television and 33% do not.

AGE OF FIRST EXPOSURE

The survey examined the age of first exposure to nudity by asking respondents when they had first seen a picture of a nude adult and when they had first seen a nude adult. The results are shown in Exhibit 43, overleaf.

Overall, a substantial number (57%) of respondents indicate that they had seen a picture of a nude adult by the time they were fifteen years old and many respondents (41%) had seen a nude adult by that age.

The survey findings indicate that individuals are being exposed to some form of material (in this case showing nudity) and to actual nudity at a fairly young age. As well, respondents are being exposed to pictorial nudity at an earlier age than to actual nudity.

EXHIBIT 43

Exposure to Pictorial and Actual Nudity

<u>Age of First Exposure (Years)</u>	<u>At what age did you see a picture of a nude adult?</u>	<u>At what age did you first see a nude adult?</u>
Under 4 years old	1%	7%
4-10	24	16
11-15	32	18
16-20	18	31
21-25	5	10
26-30	1	2
Over 30	2	1
Don't Remember	12	10
Never	1	2
Refusal/No Answer	<u>3</u>	<u>3</u>
	100%	100%



LEGAL KNOWLEDGE ABOUT SEXUALLY EXPLICIT MATERIAL

Respondents' awareness of the legalities surrounding sexually explicit material was examined. Two situations were presented, of which the first is legal and the second is illegal:

- sexually explicit material which offends their local community standards
- sexually explicit material showing scenes of violence, horror or cruelty.

In regard to the first situation, 32% of respondents correctly indicate that such material is legal, while 51% indicate it is illegal and 15% do not know.

Knowledge about material which offends local community standards is related to age, geographic area of residency and religion. The regression analysis findings are described briefly below:

- older citizens, more than young people, think that such material is illegal ($p = .0000$)
- residents of B.C. and Manitoba, more than others, think that such material is legal ($p = .0000$)
- respondents of the Catholic and Protestant religion, more than others, think that such material is illegal ($p = .0002$).

In regard to the second situation, 62% of respondents correctly indicate that this is illegal while 27% stated it is legal and 10% do not know. Our analysis reveals that the socio-demographic-economic variables which are significant in influencing this dependent variable are education, religion and geographic area of residence, as described below:



- respondents with up to 8 years of education are less inclined to believe that sexually explicit material showing violence, horror or cruelty is legal (p = .0002). Ten percent of respondents with up to 8 years of education feel this is legal compared to 30% for those with 9-13 years of education and 33% for those with more than 14 years of education
- respondents of the Catholic and Protestant religion, more than others, think that such material is illegal (p = .0252).
- residents of Alberta and Manitoba, more than others, feel such material is legal (p = .0663).

Religion and geographic area of residency appear to be common variables related to both situations probing legal knowledge. We see that Manitoba residents are inclined to think that the material is legal and Catholic and Protestant respondents tend to think the material is illegal.

Generally speaking, there is not a great deal of knowledge about the legality of specific types of pornographic material and local standards controlling this material. Although a number of respondents do have a knowledge of the facts, there are a substantial number who do not (both those who respond incorrectly and those who indicate they do not know). The pattern which emerges is that respondents generally think activities related to sexually explicit material are illegal, given that a substantial number of respondents indicate this for the two situations examined.

POLICY OPTIONS: CONTROL OVER SEXUALLY EXPLICIT MATERIAL

With respect to the control over sexually explicit material, the survey investigated respondents' opinions regarding who should take the lead role in its control. Their views concerning the role of police and censor boards in this area were also obtained. Finally, they were asked to express their views



on what should be done about particular sexually explicit scenes found in various media or locations. The results of these areas of investigation are discussed in turn.

LEAD ROLE IN THE CONTROL OF SEXUALLY EXPLICIT MATERIAL

The views of respondents concerning policy options to be taken, if any, in the control of pornography were solicited in the survey. More specifically, respondents were asked who they believed should take the lead role in controlling sexually explicit material. The responses generally reveal three major schools of thought:

- government control (59% overall)
- personal and family control or discretion (16% overall)
- police and censor board control (7% overall).

While a number of respondents obviously feel that personal choice and freedom should be used to control sexually explicit material, a much greater number feel that some type of outside control (preferably government control) is required. A few respondents indicate a preference for a lead role by police and censor boards.

We analyzed the two major response categories specified by survey respondents to the question of who should take a lead role in controlling sexually explicit material.* Our regression analysis of the relationship of the socio-demographic-economic variables and the two control options shows that:

- Francophones are more inclined to favour a government role in the control of sexually explicit material ($p = .0000$). Those with schooling greater than 14 years are least inclined to favour this option ($p = .0213$)

* A later section examines the role of police and censor boards in more depth.



- residents of Alberta and Ontario are more inclined to favour personal and family discretion (p = .0000). Older citizens tend not to favour this option (p = .0000).

Regression models were also built in order to understand the influence of the socio-demographic-economic and other explanatory variables on the two control options. The modelling results are shown in Exhibit 44, overleaf.

An examination of the Exhibit indicates that the explanatory variables influencing the dependent variables are public concepts, use, social sexual attitudes and legal knowledge. With respect to the socio-demographic-economic variables which remain in the final model, we see that Francophones are more inclined to favour a government role and residents of Ontario and the Atlantic favour personal and family discretion in the control of sexually explicit material.

Although the same explanatory variables are influencing the dependent variables, it is quite apparent that they are doing this in different ways. For example, both dependent variables are influenced by the social sexual attitude which is concerned with the appropriate level of schooling to start sex education. Proponents of starting sex education in primary school (21%), more than others, feel that personal and family discretion is required in controlling sexually explicit material. Proponents of starting sex education at a higher level (66%) are most likely to feel that a government role in controlling such material is required. These relationships are shown in Exhibit 45, overleaf.

The different influences of the explanatory variables are further elaborated below:

Public concepts: Respondents who find magazines showing nude women relatively acceptable, tend to favour personal or family discretion. Conversely, respondents who find sex magazines relatively unacceptable, favour a government role. The former tend to have relatively liberal attitudes whereas the latter lean towards conservative ideals.

EXHIBIT 44

Roles in Controlling Sexually Explicit Material
and Explanatory Variables

<u>Variable</u>	<u>T-Value</u>	<u>Significance Level</u>	<u>Interpretation</u>
<u>Personal and Family Discretion</u>			
Public Concepts	3.272	.0011	Those who find magazines available at a local store showing nude women acceptable, personal and family discretion
Area of Geographic Residency	4.347	.0000	Residents of Ontario and Alberta, more than others, personal and family discretion
Legal Knowledge	2.689	.0073	Those who think sexually explicit material which offends their local community standards is legal, personal and family discretion
Public Concepts	2.328	.0201	Those that do not consider important whether the sexually explicit material is shown for entertainment or artistic/educational reasons, personal and family discretion
Use	1.945	.0522	Those that have bought adult entertainment magazines, personal and family discretion
Social Sexual Attitudes	1.700	.0894	Those that believe sex education should be started at primary school, personal and family discretion
<u>Government</u>			
Public Concept	3.459	.0006	Those that agree sex magazines are unacceptable, government role
Language	3.259	.0012	Francophones, government role
Social Sexual Attitude	2.590	.0098	Those that believe sex education should be started in high school or college/university, government role
Legal Knowledge	2.304	.0214	Those who think sexually explicit material which offends their local community standards is illegal, government role
Use	2.087	.0372	Those who have not bought adult entertainment magazines, government role
Use	1.827	.0680	Those who have not read adult entertainment magazines, government role.

Exhibit 45

Roles in Controlling Sexually Explicit Material and
Optimum Level to Start Sex Education

At what level, if at all
should sex education
be started in schools?

		<div> <div>Never</div> <div>Primary School</div> <div>High School University/ College</div> </div>		
<u>Role in controlling material</u>	Personal and Family Discretion	9 12.1%	199 20.7%	58 13.0%
Who, if anyone should take the lead role in controlling sexually explicit materials?	Government	41 56.0%	543 56.4%	296 65.7%
	Other Groups	19 25.9%	191 19.7%	65 14.6%
	Missing	4 6.1%	30 3.1%	30 6.7%
	Total	73 100.0%	962 100.0%	450 100.0%



Use: Respondents who have more frequently bought adult entertainment magazines, tend to favour personal or family discretion. Those who have less frequently bought such magazines, tend to prefer a government role.

Legal knowledge: Respondents who believe that sexually explicit material which offends their local community standards is legal, tend to favour personal or family discretion. Those who believe this is illegal, tend to favour a government role over the control of sexually explicit material.

ROLE OF POLICE AND CENSOR BOARDS

The need to have some outside control (versus personal discretion) over sexually explicit material was further supported by responses to the following two questions:

- do you believe local police should have much more, more, less or much less power to control offensive sexually explicit material?
- do you believe that censor boards should have much more, more, less, or much less power to control sexually explicit material?

While many respondents did not indicate that these two bodies (i.e., police and censor boards) should have the lead role in controlling sexually explicit material, a substantial number did indicate that they should have more power. Their views are described below:

- 67% of respondents feel police and 66% feel that censor boards should have much more or more power to control sexually explicit material
- the present amount of control held by police and censor boards is felt to be sufficient by a fairly small percentage of respondents (22% and 17%, respectively)



- very few respondents indicate that police or censor boards should relinquish some of their power (8% and 13%, respectively).

The regression analysis performed indicates that differences in the preference for control by police are related to a number of socio-demographic-economic variables. The significant influences are described below:

- respondents who favour greater outside control tend to be female more than males (74% versus 58%). The relationship to sex is significant at $p = .0000$
- older citizens favour more control by police. This is significant at $p = .0000$.
- respondents who did not state a religious affiliation, more than others, ($p = .0023$) favour less police control. Catholic respondents, more than others, favour greater police control ($p = .0023$)
- everything else being equal, residents of the Atlantic tend to favour greater police control ($p = .0043$). Although residence does not appear in the cross-tabulations (21%- 25% approval in each case), Atlantic residents favour greater police control when age and religion are controlled.

The socio-demographic-economic variables which influence preference for police control are the same as those which influence preference for censor board control, with the exception of the province of residence. Females, older people and respondents with a religious affiliation favour greater control by censor boards (significant at $p = .0000$, $.0002$, and $.0013$, respectively). Ontario residents, more than others, favour less censor board control ($p = .0009$).



Requirement for Police and Censor Board Involvement and Explanatory Variables

We analyzed the relationship of various explanatory variables on the dependent variables - the requirement for police involvement and the requirement for censor board involvement. The final regression models are shown in Exhibit 46, overleaf. As may be observed, similar explanatory variables are related to both of these dependent variables. It should also be noted that the explanatory variables which are related to the requirement for police and censor board involvement are the same as those which are related to the requirement for a lead role for government in controlling sexually explicit material.

In examining the Exhibit, the following relationships are apparent:

Public concepts: Perceptions about the harmful effects of sexually explicit material and the level of acceptability towards such material affects the extent of police and censor board involvement desired by respondents. Respondents with greater acceptability for sexually explicit material are not as likely to feel increased police or censor board involvement is required. This relationship is illustrated in Exhibit 47a, overleaf. Fewer respondents who agree that sex magazines are acceptable, compared to those that disagree, believe police should have more power (52% versus 80%).

Use: Use (either buying adult entertainment magazines or videos) is related to how much police or censor board involvement is favoured. Exhibit 47b, overleaf, shows that fewer respondents who have bought adult entertainment magazines believe that police should have more control, than respondents who have not bought such magazines (36% versus 70%).

Social Sexual Attitudes: General social sexual attitudes and beliefs about personal liberties are very much related to the dependent variables. For example, Exhibit 47c, overleaf, shows the relationship between the requirement for police control and the level of schooling to start sex

Requirement for Police or Censor Board Involvement in
Controlling Sexually Explicit Materials and Explanatory Variables

Variable	Police		Censor Boards		Interpretation
	T-Value	Significance Level	T-Value	Significance Level	
Public Concepts	2.771	.0058			Those who agree sex magazines are acceptable, less police involvement
Public Concepts	1.356	.1757	2.903	.0039	Those who find magazines at a local store showing nude women acceptable, less police and censor board involvement
Use	3.622	.0003	2.041	.0418	Those who have bought adult entertainment magazines, less police and censor board involvement
Social Sexual Attitude	3.435	.0006	2.956	.0033	Those that agree a person can do anything as long as it doesn't harm anyone, less police and censor board involvement
Social Sexual Attitudes	3.568	.0004	-	-	Those that think sex education should be started in primary school, less police involvement
Public Concepts	3.277	.0011	3.847	.0001	Those that disagree sex magazines are degrading to women, less police and censor board involvement
Sex	3.019	.0027	2.210	.0275	Males, less police and censor board involvement
Legal Knowledge	2.321	.0207	1.879	.0609	Those who agree sexually explicit material which offends their local community standards is legal, less police and censor board
Public Concepts	1.939	.0530	-	-	Those who agree that sexually explicit material showing children is acceptable, less police involvement
Use	1.736	.0832	-	-	Those who have bought videos, less police involvement
Social Sexual Attitudes	-	-	2.646	.0084	Those that disagree the law should enforce sexual morals which agree with their own, less censor board involvement
Public Concepts			2.222	.0267	Those that do not think violent sexual material leads readers or viewer to violence, less censor board involvement
Exposure	-	-	1.589	.1127	Those that are aware of adult entertainment material (magazines, videos or movies) near their homes, less censorboard involvement

Exhibit 47

Requirement for Police Involvement
Public Concepts, Use and Social Sexual Attitudes

Requirement for Police Involvement	(a) Public Concepts			(b) Use		(c) Social Sexual Attitudes		
	Agree	Neither	Disagree	Have you bought adult entertainment magazines in the last 12 months?		Never	Primary	Secondary/ College
Do you believe that local police should have more or less power to control offen- sive sexually explicit material?	722 80.4%	227 63.9%	364 51.5%	Sex magazines are unacceptable in our society		At what level, if at all, should sex education be started in schools?		
	More	Neither more or less	Less	One or More				
	Missing	Total						
	24 2.7%	10 2.7%	19 2.7%	1264 70.0%	72 36.3%	60 82.8%	597 62.0%	328 72.8%
	28 3.1%	20 5.7%	118 16.6%	375 20.8%	64 32.5%	5 7.5%	247 25.6%	79 17.6%
	24 2.7%	10 2.7%	19 2.7%	111 6.2%	56 28.3%	4 6.1%	95 9.8%	29 6.5%
	24 2.7%	10 2.7%	19 2.7%	56 3.1%	6 2.8%	3 3.6%	25 2.6%	14 3.1%
	898 100.0%	356 100.0%	707 100.0%	1806 100.0%	198 100.0%	72 100.0%	963 100.0%	450 100.0%



education. The figures indicate that of those who state that sex education should be started in primary school, (62%) feel greater police control is necessary; of those who state it should never be started, (83%) feel greater police control is necessary.

Exposure: The relationship shown in the model indicates that those that are aware of adult entertainment materials (magazines, videos, movies), more than others, feel less censor board involvement is required. Thus, exposure to the material does not necessarily imply respondents desire greater control over it.

Legal knowledge: The same legal knowledge variable is related to the dependent variables. Respondents who state that material which offends their local community standards is legal, more than others, did not feel greater police or censor board involvement.

Socio-demographic-economic: As described above, males more than females, did not favour greater involvement of police or censor boards.

The overall picture of direct and indirect factors influencing opinions on police or censor board control is shown in Exhibit 48, overleaf. It is interesting to note that the only socio-demographic-economic variable having a direct influence is sex. The variables that are eliminated as direct factors are:

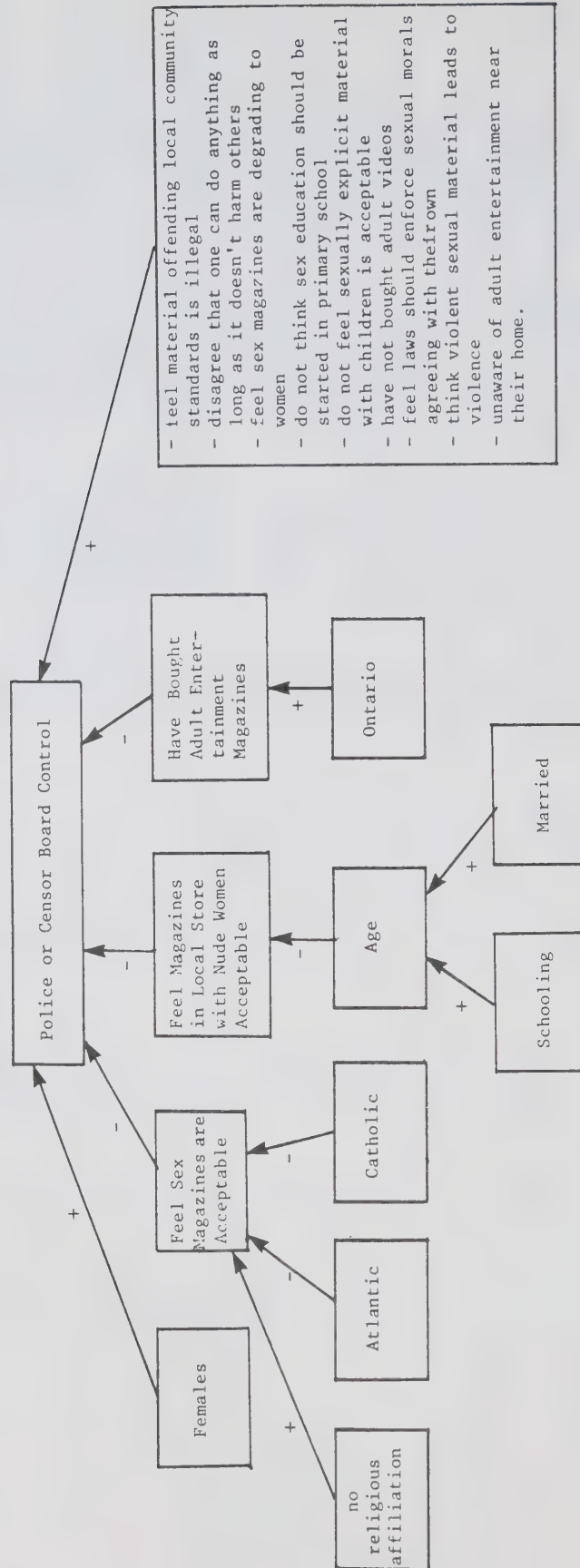
- age, which drops out since older people tend to feel magazines in local stores with nude women are unacceptable
- Ontario, since people in Ontario tend to buy more adult entertainment magazines
- religion, since Catholics find sex magazines relatively less acceptable and those without a religious affiliation relatively more acceptable

EXHIBIT 48

EFFECT OF SOCIO-DEMOGRAPHIC - ECONOMIC

VARIABLES ON THE PREFERENCE FOR POLICE OR

CENSOR BOARD CONTROL OVER PORNOGRAPHY





- Atlantic, since those in the Atlantic provinces find sex magazines relatively less acceptable.

POLICY OPTIONS - MEDIA AND SCENE SPECIFIC

A series of questions in the survey asked respondents to express their views on what should be done about particular sexually explicit scenes found in various media or locations. Views range from respondents who indicate a tolerant, do-nothing approach, to those who indicate that banning sexually explicit material is necessary. The following discussion highlights the views of the respondents according to the media in question.

Magazines

Four types of scenes were depicted in this printed media:

- violent sexual scenes shown in magazines
- sexual intercourse between two adults of the same sex
- pictures of nude women
- pictures of nude men.

Respondents generally take a much harsher stand against magazines that show violent sexual scenes and sexual intercourse between two adults of the same sex than they do for magazines that show nude women or nude men. Their position towards magazines with scenes depicting violence or sex between adults of the same sex is very similar. Magazines that show nude women or men elicit an almost identical response from survey participants.

In regard to magazines that show violent sexual scenes, 38% of respondents indicate banning such material is most appropriate. Some type of outside censorship is indicated by 14% (remove offensive parts) and another 13% suggest advertising that it may be offensive to some people. Another 13% indicate children should not be allowed to be sold such material.



The same type of respondent attitude is revealed for magazines showing sexual intercourse between adults of the same sex. Again, many respondents feel banning the material is most appropriate (35%). This is followed by respondents who feel children should not be allowed to be sold such magazines (18%). Thirteen percent think it should be advertised that the material may offend and 9% indicate that an outside censorship approach should be taken (remove offensive parts).

Because respondents give almost identical suggestions to deal with nude women and nude men in magazines, it appears that they do not differentiate among the scenes being depicted. The action most frequently mentioned is to forbid selling this material to children (34% for nude women and 32% for nude men). A tolerant approach (personal discretion) is taken by 19% for both kinds of scenes in magazines; however, a more restrictive approach (ban the material) is expressed by an identical proportion of respondents.

Television

The scenes described on television shows were:

- late night entertainment programs showing sexual intercourse between a man and a woman
- nude adults at hours when children might be watching.

In the first case, many respondents (31%) indicate nothing should be done and that the viewing of such shows should be left to personal or family discretion. Some sort of forewarning is suggested by 27% (advertise that it may offend) and a censorship approach is declared by 11% (censor to remove offensive parts). Another 19% feel that such material should be banned.

In the second case, the action chosen by the largest group (31%) is to forbid showing such material when audiences might include children or juveniles. The next most favoured options are to ban such material completely (25%), leave it to personal or family discretion (13%) and advertise that it may offend (12%).



Films

Two types of scenes were described for the film media:

- unrestricted entertainment movies which show nude adults
- theatres restricted to adults which show sex associated with violence.

A much more tolerant view is held towards the first scene (with nude adults) than for the second (with sex associated with violence).

Personal and family discretion in the viewing of movies which show nude adults is indicated by 24% of respondents. Another 22% feel that these movies should be advertised as containing material which may offend some people, and 12% feel the offensive parts should be removed. The restriction of these movies to children or juveniles is indicated by 19% and 12% feel the need to ban the material completely.

The second case (sex associated with violence) prompts a large number of respondents (36%) to opt for banning such shows completely. Fifteen percent of the respondents express the need to advertise that the material may offend and 13% suggest a censorship approach (removal of the offensive parts). Eleven percent indicate that the presentation of these movies should be forbidden to children or juveniles.

Public Art Gallery

The most tolerant views are expressed about sexually explicit paintings exhibited in a public art gallery. Forty-nine percent of respondents indicate that viewing such material should be left to personal or family discretion. This is followed by 17% who feel such material should be advertised as containing potentially offensive material, 11% who feel such shows should be banned, and 10% who feel children should not be allowed access.



A Comparison of Actions Suggested to Deal
with Specific Sexually Explicit Material

Exhibit 49, overleaf compares the actions suggested by respondents to deal with each type of sexually explicit material discussed above. The major findings are described below:

- banning the material, perhaps the most repressive action, is mainly indicated for scenes showing violence or sexual intercourse between adults of the same sex. The media in which these scenes are shown does not influence the action chosen
- forbidding the material to be presented or sold to children are the preferred actions in cases where children could be a potential audience or have access to the material. Banning such material is also suggested in the case of nude adults on television when children might be watching or nude adults (women or men) in magazines
- family or personal discretion, combined with a forewarning that the material may be offensive, is felt to be the most appropriate action for scenes showing heterosexual intercourse on late-night television, nude adults in entertainment movies and sexually explicit paintings in an art gallery
- fining or jailing the producers is the least preferred measure indicated by respondents for all media and scenes
- overall, the least repressive measures are suggested for sexually explicit material in an art gallery.

In summary, respondents suggest quite strong action for material showing violence and homosexual intercourse and for material which can be accessible to children. Less repressive action is suggested for material showing nude adults and heterosexual intercourse. We see that the more repressive actions are favoured for situations which are considered to be less acceptable to respondents (as determined in our conjoint analysis).

Actions to Deal with Sexually Explicit Scenes in Different Media

Scene and Media	Action to be Taken					
	Nothing/ Personal or Family Discretion	Remove Offensive Parts	Forbid Presentation/ Access/ Selling to Children	Advertise It May Offend	Fine or Jail Producer	Ban Such Material
Violent sexual scenes shown in magazines	9%	14%	13%	13%	4%	38%
Sexual intercourse between two adults of the same sex in entertainment magazines	13	9	18	13	4	35
Entertainment magazines, which could be sold at a local store or newsstand, which include pictures of nude women	19	7	34	11	3	19
Entertainment magazines, which could be sold at a local store or newsstand, which include pictures of nude men	19	7	32	12	3	19
Late night entertainment programs showing sexual intercourse between a man and women	31	11	-	27	3	19
Entertainment programs on TV which show nude adults at hours when children might be watching	13	9	31	12	2	25
Unrestricted entertainment movies which show nude adults	24	12	19	12	2	12
Theatres restricted to adults which show sex associated with violence	12	13	11	16	3	36
Sexually explicit paintings in an art gallery	49	5	10	17	1	11



We also see that respondents are not influenced by the media in choosing specific measures to deal with sexually explicit material; however, they are influenced strongly by the scene and audience and somewhat by the artistic/educational value of the material. These findings, again, are supported by the results of the conjoint analysis and by another survey question which asked respondents to rate how important the scene, audience and artistic/educational value are in their selection of an appropriate action to deal with sexually explicit material. The findings, shown in Exhibit 50, overleaf, indicate:

- the action chosen is most influenced by whether violent scenes are depicted or children might be a likely audience
- the explicitness of the sexual scene is the next most important criterion in judging what should be done
- the artistic or educational value (versus solely entertainment purposes) is least important of the four criteria, but is nevertheless a consideration in deciding what should be done.

SUMMARY OF SURVEY FINDINGS REGARDING PORNOGRAPHY ISSUES

Summary findings are described in relation to the five major issue areas elaborated in the foregoing chapter. We then review the influence of the explanatory variables (e.g., public concepts, exposure, legal knowledge, and the socio-demographic-economic variables).

PUBLIC CONCEPTS

- In regard to the issue of pornography, in general, approximately equal numbers of respondents feel pornography is acceptable as it is unacceptable.
- Respondents feel that individuals have a greater right to view sexually explicit material than producers have to produce it.

EXHIBIT 50

Importance of Four Criteria on
Action to be Taken to Deal with
Sexually Explicit Material

<u>Criteria</u>	<u>Importance Rating</u>		
	<u>Not at All</u>	<u>Somewhat</u>	<u>Very</u>
Level of Violence Shown	4%	13%	73%
Children are Likely to See the Scenes	4%	17%	71%
Explicitness of the Sexual Scenes	12%	24%	56%
Primary Purpose of Material is Entertainment Rather than Art or Education	15%	31%	45%



- Respondents do not consider all types of pornography with equal levels of acceptability. Audience is the most important determinant of acceptability, followed closely by scene. Medium has little relative impact on acceptability.
- Viewing sexually explicit material by children is much less acceptable than viewing by oneself or other adults.
- Of the five scenes examined, a scene combining sex with violence and scenes showing homosexual intercourse are most offensive. These are much more offensive than one or more nude men and heterosexual intercourse. A scene with one or more nude women is the most acceptable of the five scenes.
- A given scene and audience for television seems to be somewhat more acceptable than the same scene and audience for magazines and films.
- The least acceptable situation is sex with violence, children as an audience and on film. The most acceptable is nude women, with other adults in the audience and on film.
- Half of the respondents indicate that they would be offended if they saw sexually explicit material near their homes.
- The views of respondents in relation to the alleged harms of pornography indicate that the prevalent thinking is that pornography does have harmful effects.

Use Patterns

- A large number of respondents report never having bought adult entertainment magazines (89%) or video cassettes (88%). Television, more than magazines and video cassettes is the medium where most respondents view adult entertainment. Fifty-seven percent of respondents have seen adult entertainment on television in the last twelve months while 41% have not.



- It appears that the majority of respondents who buy or leaf through magazines are consuming magazines which are generally categorized as soft core.
- Although there are some switches among media as to where specific scenes are being viewed most often, the pattern of responses indicates that one or more nude women and a man and woman engaged in sexual intercourse are most frequently being viewed. This is followed in frequency by scenes showing one or more nude men, homosexual intercourse and sex combined with violence. The pattern follows exactly the level of acceptability (found in our conjoint analysis) held towards these scenes.
- Very few respondents view adult entertainment on all three media (6%). Most respondents view adult entertainment on television only (31%). A third of respondents never consume adult entertainment on any of the three media.

Exposure

- On the whole, a substantial number of respondents are aware of the availability of a general type of adult entertainment near their homes (73%). Knowledge about material showing violence or scenes with children is much less widespread (43% and 15%, respectively).
- The extent of knowledge about the availability of sexually explicit material differs by province but not by community size. Respondents in British Columbia are most aware of this material near their homes. Respondents who reside in small communities are as knowledgeable about the availability of sexually explicit material as those that are in larger communities.
- Most respondents (74%) consider pornography to be easily available to everyone.
- Respondents are being exposed to material showing nudity at a fairly young age. As well, respondents are being exposed to pictorial nudity at an earlier age than to actual nudity.



Legal Knowledge

- Overall there is not a great deal of knowledge about the legality of specific types of pornographic material and local standards controlling this material.
- Respondents generally think activities related to sexually explicit material are illegal.

Policy Options

- A substantial number of respondents indicate a need for a government role in the control over sexually explicit material. Another group of respondents favour personal and family discretion in the control over this material (16%).
- A substantial number of respondents feel police and censor boards should have more power to control sexually explicit material (67% and 68%, respectively).
- Respondents do not suggest the same control options for all types of sexually explicit material. Respondents suggest quite strong action for material showing violence and homosexual intercourse and for material which is accessible to children. Less repressive action is favoured for material showing nude adults and heterosexual intercourse. As can be observed, the more repressive actions are favoured for situations which are considered to be less acceptable to respondents (differences in acceptability levels were determined in our conjoint analysis).
- The level of violence shown in a scene, the accessibility of the material to children and the level of sexual explicitness portrayed in a scene are all important considerations influencing what action is favoured to deal with sexually explicit material. The artistic/educational value of the sexually explicit material is also a consideration influencing the action selected, although somewhat less important.



- Respondents are more inclined to favour taking action against the material, once it is in circulation, than on stopping the source of the material (fining or jailing the producer).

Influence of the Explanatory Variables on Pornography Issues

The influence of the socio-demographic-economic and other explanatory variables on selected pornography dependent variables are summarized in Exhibit 51, overleaf. In order to integrate the various relationships shown in the Exhibit we developed a model which is a wrap-up of the influences and interactions among the explanatory variables. The model is shown in Exhibit 52, overleaf, and integrates the relationships influencing the control option -- the requirement for a government role in the control over sexually explicit material.

The major highlights are as follows:

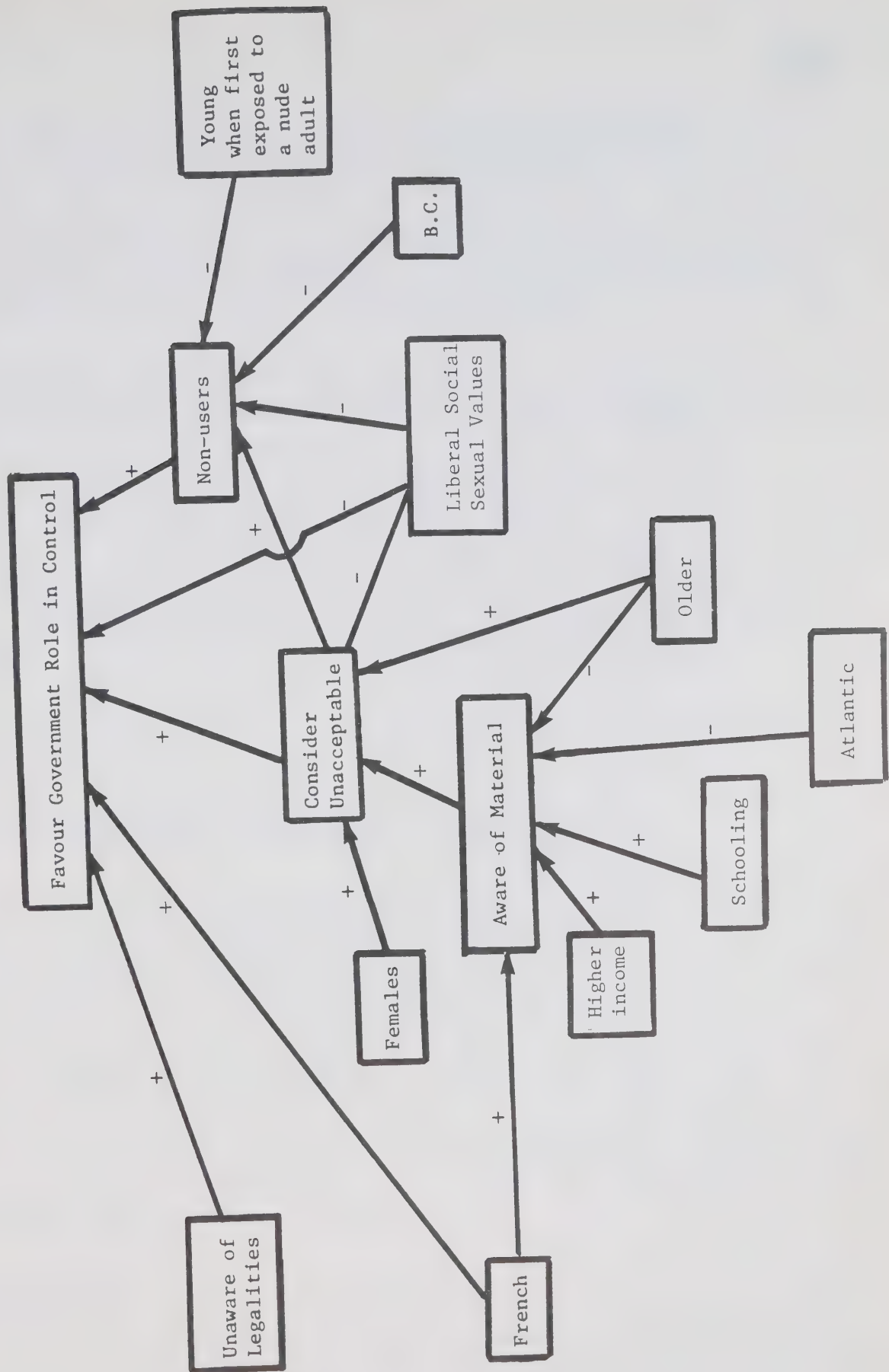
- those unaware of the legalities regarding pornography, non-users, those with conservative social sexual values, those who consider adult entertainment material unacceptable, and those speaking French tend to favour government control
- use of adult entertainment material is directly influenced by age of first exposure to a nude adult, social sexual attitudes, and acceptability. Those living in British Columbia also have a relatively higher use
- acceptability is influenced by social sexual attitudes and awareness. Older people and females consider adult material relatively less acceptable
- awareness of sexual materials is higher among the younger, higher income, more educated French-speaking people and those outside the Atlantic provinces.

RELATIONSHIP OF SELECTED PORNOGRAPHY DEPENDENT VARIABLES AND SIGNIFICANT
EXPLANATORY VARIABLES*

Explanatory Variable	DEPENDENT VARIABLE						Personal Discretion in Controlling Sexually Explicit Material	Control by Censor Boards
	Sex Magazines are Unacceptable in our Society	Acceptability of Adult Entertainment Near Homes	Pornography has Effect on Commission of Acts of Violence	Frequency Viewing Adult Entertainment Television	Awareness of adult Entertainment	Government Role in Controlling Sexually Explicit Material		
Age	Older people, agree	Older people, less acceptable	Older, agree		Older, less aware		(Older, not personal discretion)	(Older, favour more censor board control)
Sex	Females, agree	Females, less acceptable	Females, agree					Females, favour more censor board control
Marital Status		Married, less acceptable	Married, agree	(Married people, more)				
Education		Less than 8 years schooling, more acceptable			More educated, more aware	(More educated, not government role)		
Religion		Protestants, less acceptable						(No religion, less control Catholics, more control)
Language			Anglophones, agree		Francophones, more aware	Francophones, government role		
Geographic Area of Residency				B.-C. residents, more	Atlantic, least aware		Ontario, Alberta, personal discretion	(Ontario, less control)
Community Size				(Large communities, less)				
Income					Higher income earners, more aware			
Social Sexual Attitudes	Liberal attitudes, disagree			Liberal attitudes, more		Conservative attitudes, government role	liberal attitudes, personal discretion	Liberal attitudes, less control
Public Concepts				Wide levels of acceptability, more		Tight levels of acceptability, government role	Wide levels of acceptability, personal discretion	Wide levels of acceptability, less control
Use	Users, disagree					Less frequent users, government role	More frequent users, personal discretion	Users, less control
Exposure	Not aware of material, disagree							
Legal Knowledge						Unaware of legalit- ies, government role	Aware of legalities, personal discretion	Aware of legalities, less control
Age of first exposure				Older, when exposed, less				

* Variables in brackets did not appear in the final model which combines socio-demographic-economic variables with other explanatory variables

Relationship of Preferences for a Government Role and Explanatory Variables





IV - A COMPARISON OF PROSTITUTION AND PORNOGRAPHY ISSUES

This part of our analysis involved a comparison of respondents' views and attitudes toward pornography and prostitution. The analysis comprised three areas:

- A comparison of aggregate findings from the two previous chapters.
- A review of the consistency of views among respondents regarding prostitution and pornography issues.
- An examination of common trends and patterns in respondents' views about these two issues and whether there are common elements influencing these views (i.e., socio-demographic-economic and other explanatory variables). These again are based on aggregate findings from the previous chapters.

In regard to consistency, we examined:

- whether respondents view prostitution and pornography in a similar manner, or whether they view them as separate issues
- whether those who use prostitution services are the same individuals who consume pornography
- whether the same respondents are being exposed to pornography and prostitution
- whether respondents are equally knowledgeable about the facts relating to prostitution and pornography
- whether respondents propose similar control options for both issues.



We note that the extent to which valid comparisons can be made is limited by the questions in the survey. In very few instances are directly comparable questions asked for both pornography and prostitution. As a result, comparisons are made on questions which are intended to elicit views on a particular issue area (e.g., level of acceptability, harmful effects of pornography and prostitution, etc.), and emerging patterns are reported.

The chapter is organized in an identical fashion to the two preceding chapters. First public concepts are examined. This is followed by a review of usage, exposure, legal knowledge, and finally, policy options.

PUBLIC CONCEPTS TOWARD PROSTITUTION AND PORNOGRAPHY

Public concepts were examined by reviewing levels of acceptability toward pornography and prostitution and perceptions about their harms. These are described in turn.

Level of Acceptability

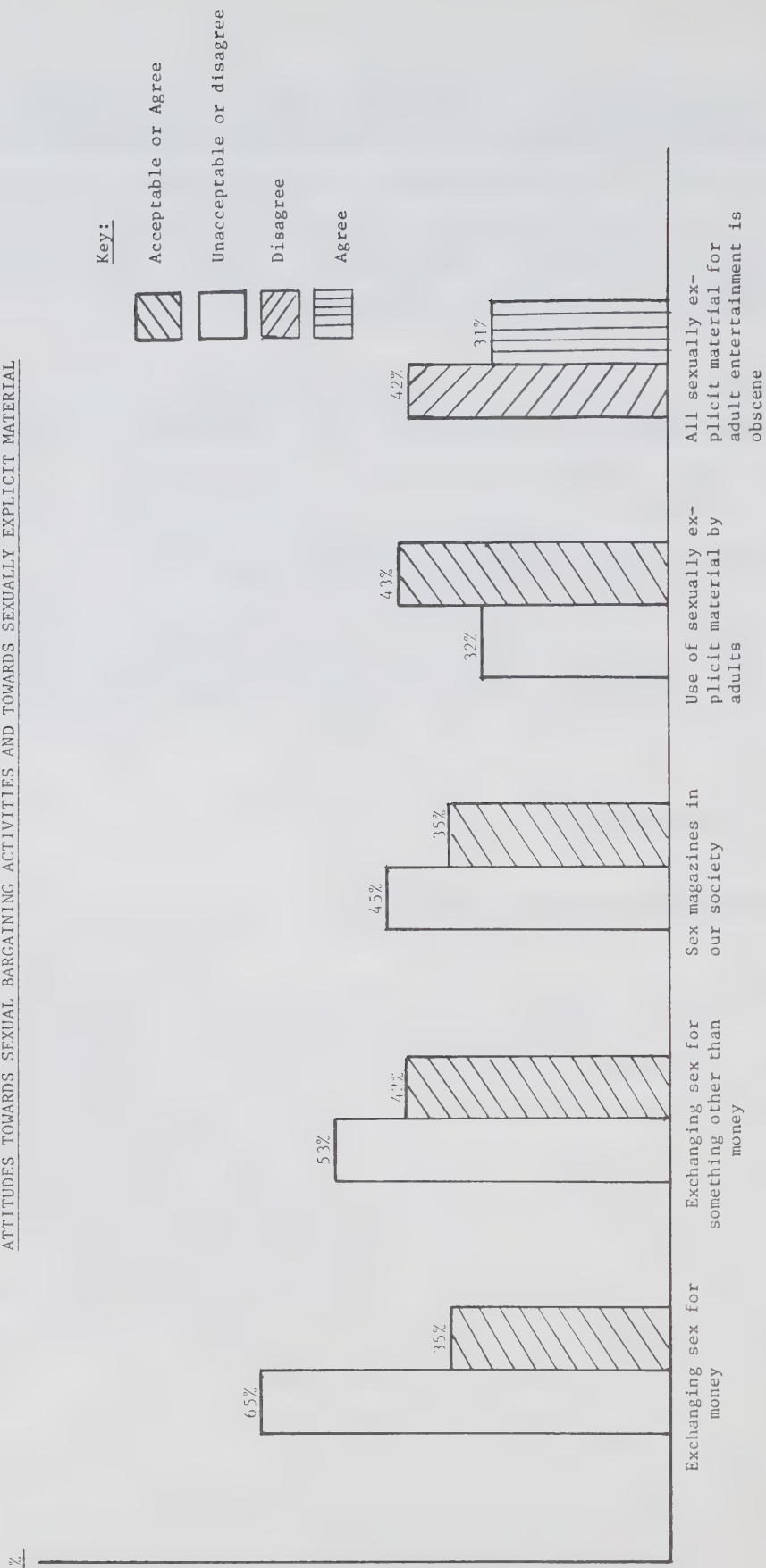
Comparison of Aggregate Results

The level of acceptability held toward the sexual bargaining activities and sexually explicit material is examined in Table 9, overleaf. With respect to the sexual bargaining activities, the pattern which emerges is that a greater percentage of respondents find these activities unacceptable, while a substantial number find them morally acceptable. A clear pattern does not arise with respect to respondents' general levels of acceptability and attitudes towards sexually explicit material, since small percentage differences are revealed in all three questions being considered.* Overall, we see that the respondents' acceptance of the sexual bargaining activities and of the sexually explicit material is quite similar.

* The failure to elicit a clear pattern for the level of acceptability towards sexually explicit material is probably attributable to the general nature of the questions used to examine attitudes. Our conjoint analysis showed more definite patterns of acceptability, once the scene, audience and media were incorporated into the analysis.

TABLE 9

ATTITUDES TOWARDS SEXUAL BARGAINING ACTIVITIES AND TOWARDS SEXUALLY EXPLICIT MATERIAL





A different picture is revealed when we compare acceptability levels towards the sexual bargaining activities and toward specific types of sexually explicit material, as shown in Table 10, overleaf. The Table indicates that respondents feel that certain types of sexually explicit material (i.e., heterosexual intercourse on late-night television and magazines showing nude women) and sexual bargaining activities are equally acceptable. However, we observe that some sexually explicit materials (i.e., magazines showing homosexual intercourse, adult-only movies showing violence and television showing nude adults when children might be watching) are considered less acceptable than the sexual bargaining activities.

We see, therefore, that in a general context, pornography and sexual bargaining are considered equally acceptable. However, if the sexually explicit material is defined in the context of a specific scene or audience, differences emerge in what respondents consider acceptable. Sexual bargaining becomes more acceptable than certain types of sexually explicit material, i.e., material showing homosexual intercourse or violent sexual scenes and material which is accessible to children.*

Levels of Acceptability and Consistency

In order to determine whether there was consistency in the views expressed by respondents toward the sexual bargaining activities and sexually explicit material, we compared responses in a cross-tabulation. The cross-tabulation of the level of acceptability towards sex in exchange for money and the acceptability of sex magazines is shown in Exhibit 53a, overleaf. Attitudes towards these two issues are very significantly linked ($p = .0000$).

Examining Part a of this Exhibit, we see that respondents, overall, have very similar levels of acceptability toward each issue. Thirty-five percent find each issue acceptable and approximately 62% find each unacceptable. A substantial number of respondents hold the same view about both issues (62%), while 32.5% switch their views. Of these latter individuals, 16.4% find the

* As described in Chapter III, scenes showing homosexual intercourse and violent sexual scenes are most offensive to respondents. As well, viewing by children is much less acceptable than viewing by oneself or other adults.

TABLE 10

ACCEPTABILITY OF SEXUAL BARGAINING ACTIVITIES AND SPECIFIC TYPES OF
SEXUALLY EXPLICIT MATERIAL

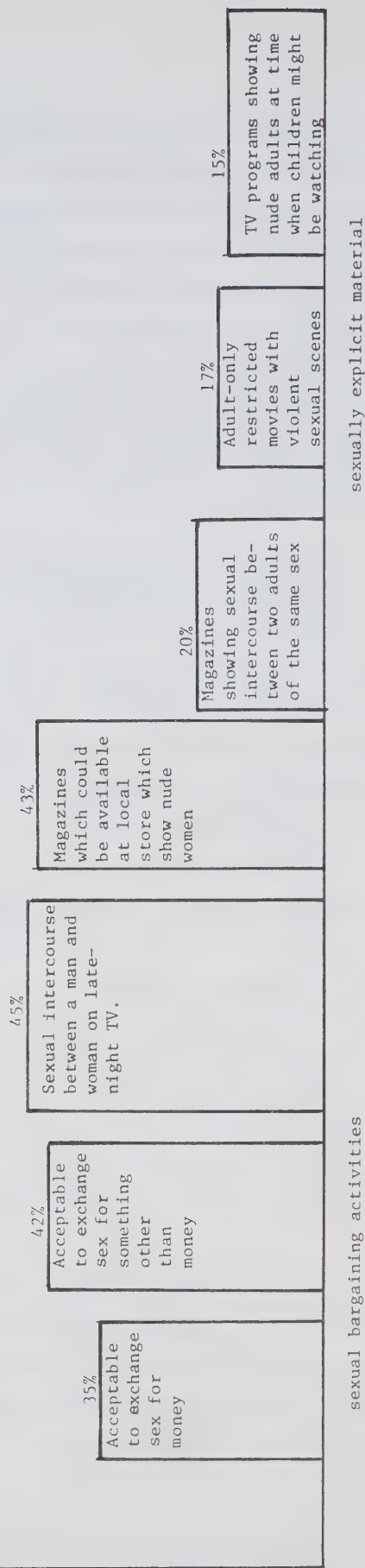


EXHIBIT 53

ACCEPTABILITY OF SEXUAL BARGAINING ACTIVITIES
AND OF SEX MAGAZINES

a) Acceptability of Exchanging Sex for Money and
Attitudes Toward Sex Magazines in Our Society

		<u>Sex magazines are acceptable in our society</u>			<u>Row</u>
		<u>Agree</u>	<u>Disagree</u>	<u>Missing</u>	<u>Total</u>
<u>Moral acceptability of exchanging sex for money</u>	Acceptable	359 17.8%*	330 16.4%	18 .8%	707 35.0%
	Unacceptable	325 16.1%	895 44%	23 1.1%	1243 61.6%
	Missing	23 1.1%	29 1.4%	16 .8%	68 3.4%
	Column	707	1254	57	2018
	Total	35%	62.2%	2.8%	100%

*Total %

Significance level: $p = .0000$

b) Acceptability of Exchanging Sex for Something Other Than Money and
Attitudes Toward Sex Magazines in Our Society

		<u>Sex magazines are acceptable in our society</u>			<u>Row</u>
		<u>Agree</u>	<u>Disagree</u>	<u>Missing</u>	<u>Total</u>
<u>Moral acceptability of exchanging sex for something other than money</u>	Acceptable	402 19.9%*	429 21.2%	22 1.0%	853 42.3%
	Unacceptable	277* 11.2%	784 39.9%	15 .7%	1074 53.2%
	Missing	29 1.4%	41 2.0%	21 1.0%	91 2.6%
	Column	707	1254	58	2018
	Total	35%	62.2%	2.8%	100%

*Total %

Significance level: $p = .0000$



pornography issue unacceptable and the prostitution acceptable, and 16.1%, conversely, find monetary sexual bargaining acceptable and sex magazines unacceptable.

Part b of the Exhibit illustrates the relationship between acceptability of exchanging sex for something other than money and attitudes toward sex magazines. We see that 1,186 (402 + 784), or 60% of the respondents answer in the same manner on both issues. Of the 48.7% who have different views on each issue, 21% find non-monetary sexual bargaining acceptable and sex magazines unacceptable and 11% find the converse to be true. This shift is consistent with the overall finding that non-monetary sexual bargaining is more acceptable than sex magazines to respondents.

Common Explanatory Variables Influencing Level of Acceptability

The explanatory variables influencing acceptability, shown in Table 9, were examined in the preceeding chapters.

We found that the levels of acceptability differed by a number of socio-demographic-economic factors, of which sex and religion have a common relationship with attitudes toward the sexual bargaining activities and toward sexually explicit material. Males and respondents without a religious affiliation tend to find the sexual bargaining activities more acceptable than others. These groups also have wider levels of acceptability towards sexually explicit material.

There are also a number of other explanatory variables which influence levels of acceptability towards the sexual bargaining activities and towards sexually explicit material (when considering the acceptability of sex magazines as the dependent variable). Strongly related to both issues are social sexual attitudes, use and exposure.



Respondents with more liberal social sexual attitudes tend to have higher levels of acceptability towards sexual bargaining and towards the acceptability of sex magazines. With respect to use, it is not surprising that respondents who have paid money in exchange for sex and who have read adult entertainment magazines are more inclined to find these activities acceptable. Exposure, through knowing someone who has given money or accepted money in exchange for sex and through awareness of the availability of sexually explicit material, is positively related to wider acceptability levels toward the sexual bargaining activities and toward sexually explicit material.

Public Perceptions About the Harms of Pornography and Prostitution

Comparison of Aggregate Results

Prostitution and pornography are alleged to cause various types of social harm. The survey elicited the opinions of respondents regarding a number of these allegations. As shown in the previous chapters, the prevalent thinking among respondents is that prostitution and pornography do have harmful effects. In particular, respondents voice near unanimous concern regarding their harmful effects on children. A substantial number of respondents indicate they feel prostitution and pornography have harmful effects on children and the great majority find sexually explicit material showing children unacceptable.

Perceptions About Harms and Consistency

In order to determine whether there is consistency in the views regarding the harms of pornography and prostitution, we compared respondents attitudes on two of these alleged harms. The cross-tabulation shown in Exhibit 54, overleaf, compares the responses to two questions dealing with the harms of prostitution and pornography on children. We see that attitudes towards the two issues are very significantly linked ($p = .0000$). As well, the aggregate results show that most respondents agree with the harms of both issues, with slightly more

EXHIBIT 54

HARMS OF PROSTITUTION AND PORNOGRAPHY

Street solicitation where there
are children is bad for children

		<u>Agree</u>	<u>Neither Agree Nor Disagree</u>	<u>Disagree</u>	<u>Missing</u>	<u>Row Total</u>
The availability of sex magazines in areas frequented by children is bad for children	Agree	1136 69.3%*	29 1.8%	50 3.0%	73 4.4%	1289 78.9%
	Neither Agree Nor disagree	91 5.5%	19 1.1%	5 0.3%	4 0.2%	119 7.3%
	Disagree	128 7.8%	13 0.8%	35 2.1%	15 0.9%	190 11.6%
	Missing	25 1.5%	1 0.0%	5 0.3%	12 0.6%	43 2.6%
	Column Total	1380 84.1%	61 3.7%	96 5.8%	104 6.3%	1641 100%

*Total %

Significance level: $p = .0000$



agreeing on the prostitution issue than on the pornography issue (84% versus 79%). Overall, the cross-tabulation shows that most respondents have the same views on both issues, with 69% of respondents answering in agreement on both issues and 2% in disagreement. The major shift in views appears with the 8% of respondents who agree with the harms of solicitation but not with the harms of sex magazines. The opposite shift is smaller, i.e., 3% of respondents agree sex magazines are bad for children and disagree that street solicitation is bad. This merely confirms the overall finding that there is more harm associated with the prostitution issue.

Harms and Explanatory Variables

A number of socio-demographic-economic variables were found to be related to allegations about the harms of prostitution and pornography. These variables, and their relationship to the different harms, are shown in Exhibit 55, overleaf. We see that language, age and marital status have a common, statistically significant relationship to both issues:

- An interesting variation is seen with Francophones. Although they tend to agree on the harmful effects of prostitution, their views shift with regard to the harmful effects of pornography.
- Older citizens and married respondents tend to agree with the harmful effects of both pornography and prostitution.

USE: EXCHANGE OF MONEY FOR SEX
AND CONSUMPTION OF ADULT ENTERTAINMENT

Comparison of Aggregate Results

The extent to which respondents are participating in the exchange of money for sex or in the consumption of adult entertainment material was described earlier. Only 4% of males state they have given money in exchange for sex. With respect to the consumption of adult entertainment material, 57% of the respondents indicate viewing it on television, 32% in magazines (reading or leafing), and 11% on video cassettes.

EXHIBIT 55

CHARMS OF PROSTITUTION AND PORNOGRAPHY AND SOCIO-DEMOGRAPHIC-ECONOMIC VARIABLES

	Prostitution is a Major Cause in the Spread of Venereal Disease	Prostitution's Effect on Property Values	Prostitution's Effect on Traffic and Noise	Street Solicitation in Areas Where There Are Children	Pornography's Effect on Commission of Acts of Violence	Pornography's Effect on Imitation of Acts of Violence	Sex Magazines are Degrading to Women
Language	Francophones, agree	Francophones, agree			Francophones, agree	Anglophones, agree	
Occupational Group	Technical, semi-professional and small business owner and skilled, semi-skilled and unskilled occupations, disagree	Skilled, semi-skilled and unskilled, and clerical sales and service occupation, agree		Skilled, semi-skilled and unskilled professional group, disagree		Professional, big business owner and administrator, occupational group, disagree	
Marital Status		Married, agree		Married, agree	Married, agree		
Religion		Protestants, agree					
Education						Schooling less than 8 years, agree	
Age			Older, agree		Older, agree		Older, agree
Geographic Area			Manitoba, agree Quebec, disagree				
Community Size			Larger communities, agree				
Sex					Females, agree	Females, agree	Females, agree



These results show that consumption of adult entertainment material is more frequent than the payment of money in exchange for sexual services. For all three types of media investigated, consumption of pornographic material exceeded the frequency of payment for sexual services. Even the proportion of respondents who consume adult entertainment on all three media (6%) exceeds the proportion who have paid for sexual services.

Consistency of Consumption of Adult Entertainment and Payment for Sex

We compared use of sexually explicit material on television with having paid money in exchange for sexual services. This was done in order to determine whether consumers of pornography are users of prostitution services. The results shown in the cross-tabulation in Exhibit 56, overleaf, confirm that a positive relationship exists between the two issues. We see that respondents who have made use of adult entertainment material tend to give money in exchange for sexual services more than those who never use sexually explicit material (3% versus 1%). The converse is also true, with respondents who have paid money in exchange for sex tending to consume relatively more sexually explicit material than those who never give money for sexual services (79% versus 56%). Most respondents have never paid money in exchange for sex but have seen adult entertainment on television (1,088 individuals or 54% of the total).

Similar results are found when comparing the consumption of adult entertainment magazines and videos with payment of money in exchange for sex (not shown). For all media the relationship is significant at $p = .0000$. The strength of the association is greatest with videos, followed by magazines and television (chi-squared value* = 521.6, 336.8 and 235.7 respectively).

* Chi-squared values measure the strength of association between variables. A higher chi-squared value denotes a stronger relationship; in this case, the relationship between adult video and payment of money in exchange for sex is stronger than the relationship of adult magazine or television use and the payment of money in exchange for sex.

EXHIBIT 56

USE OF ADULT ENTERTAINMENT MATERIAL IN
THREE MEDIA AND PAYMENT OF MONEY FOR SEXUAL SERVICES

How often, if ever, have you seen entertainment
programs on TV showing nude adults in the last 12
months?

		<u>Never</u>	<u>Once or More</u>	<u>Missing</u>	<u>Row Total</u>
<u>Have you ever given money in exchange for sex?</u>	No	815 42.1%* 97.7%**	1088 56.2% 95.8%	34 1.7% 69.4%	1936 100% 96.0%
	Yes	9 18.5% 1.1%	38 79% 3.3%	1 1.7% 1.7%	48 100% 2.4%
	Missing	10 30.8% 1.3%	9 27.6% .8%	14 41.5% 29.0%	34 100% 1.7%
	Column	<u>834</u> 100%	<u>1135</u> 100%	<u>49</u> 100%	<u>2018</u> 100%
	Total	41.3%	56.3%	2.4%	100%
	Significance: p = .0000				

* Row Total

** Column Total



Use and Explanatory Variables

The two previous chapters have examined the influence of the explanatory variables on use. There is some commonality among the socio-demographic-economic variables which influence the use of adult entertainment material and payment of money for sexual services. Sex is strongly related to both issues, with males more than females tending to be consumers of adult entertainment magazines and to have paid money in exchange for sex. Geographic area of residency also influences consumption of adult entertainment material and payment of money in exchange for sexual services, with residents of B.C. tending to be consumers or users more than others.

There is also some commonality among the other explanatory variables which influence the use of adult entertainment material and payment of money for sexual services. The most common explanatory variable influencing use of all media is public concepts or the level of acceptability toward sexually explicit material. Respondents who have a tolerant attitude toward various forms of sexually explicit material tend to consume relatively more adult entertainment material. Similarly, respondents who have a wide level of acceptability toward sexual bargaining tend to have paid money in exchange for sex.

Exposure also has a relationship to whether or not adult entertainment material is consumed and money is paid in exchange for sexual services. Respondents' awareness of the existence of such material near their homes (exposure) is strongly related to its consumption in magazines and on television. Exposure of a different type influences whether respondents have paid money in exchange for sexual services. Those who have been exposed, as a result of sharing the experience of others who have given money in exchange for sex, tend to have done so themselves.

The social sexual attitudes of respondents who consume sexually explicit material tend to be relatively liberal, compared to non-consumers. Conversely, the social sexual attitudes of respondents who have given money in exchange for sexual services tend to be relatively conservative.



EXPOSURE TO PROSTITUTION AND ADULT ENTERTAINMENT

Comparison of Aggregate Results

Exposure to prostitution activities and sexually explicit material is examined in Table 11, overleaf. Respondents' awareness of solicitation on the streets of their residential neighbourhood or where they do grocery shopping is not substantial. Most respondents never see solicitation. In contrast, a substantial number of respondents are aware of the availability of adult entertainment material (films, videos, etc.) near their homes. They have less knowledge of the availability of such material showing scenes with violence and much less knowledge of such material showing scenes with children. Nevertheless, there is much more awareness about the availability of adult entertainment material near respondents' homes than about solicitation activities.

Exposure and Consistency

In order to determine whether the same respondents who are aware of the availability of adult entertainment are those who are aware of the occurrence of street solicitation, we compared survey responses on these two issues. Exhibit 57, overleaf, shows the cross-tabulation of awareness of sexually explicit material near respondents' homes and awareness of solicitation activities.

We see that most respondents are aware of adult entertainment material but not of solicitation near their home (54%). This finding concurs with the overall findings that knowledge of adult entertainment is more widespread than of solicitation. Approximately 11% of respondents are aware of both adult entertainment and solicitation, while a similar proportion (10%) are not aware of either of these near their homes. Very few respondents (.6%) are aware of solicitation without being aware of adult entertainment.

TABLE 11

AWARENESS OF PROSTITUTION ACTIVITIES AND SEXUALLY EXPLICIT MATERIAL

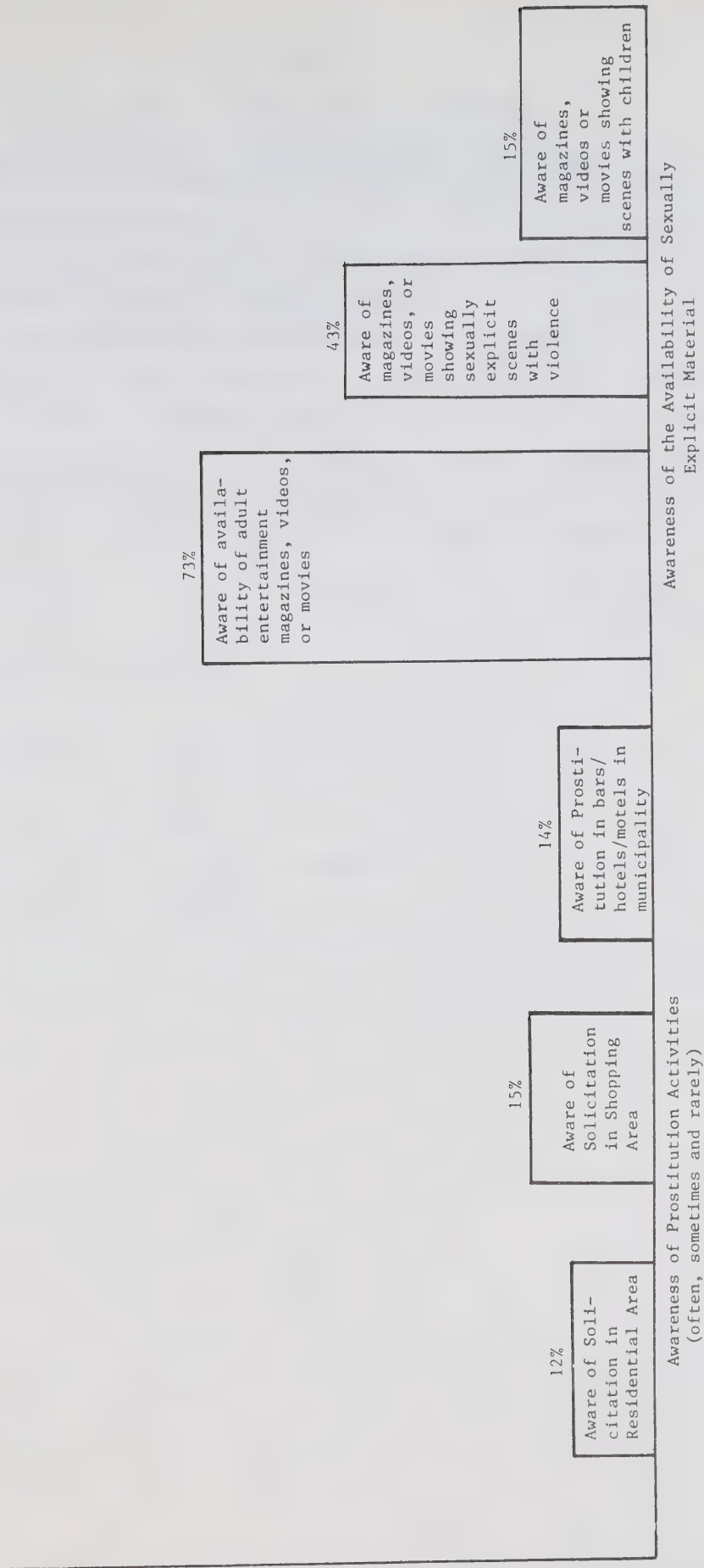


EXHIBIT 57

AWARENESS OF ADULT ENTERTAINMENT MATERIAL NEAR RESIDENTIAL HOMES AND VISIBILITY OF SOLICITATION ON RESPONDENTS' RESIDENTIAL STREETS

To the best of your knowledge, are "adult
entertainment" magazines, videos or movies
available near your home?

		<u>Yes</u>	<u>No</u>	<u>Missing</u>	<u>Row Total</u>
How often, if at all, does solicitation for the purposes of prostitution take place on the streets of your residential neighbourhood? <u> </u>					

Significance p = .0000

* Row %
** Column %
*** Total %



The Exhibit also shows that awareness about adult entertainment material implies awareness about solicitation. Of those who are aware of adult entertainment near their homes, 15% indicate street solicitation occurs (often, sometimes or rarely) in their residential neighbourhood. However, of those unaware of adult entertainment near their homes, less than half the percentage, 6.2% find solicitation (often, sometimes or rarely) in their neighbourhood. The reverse trend is also true, with respondents who are aware of solicitation near their homes more inclined to see adult entertainment in their residential neighbourhoods. We see that 87% of respondents who find solicitation in their neighbourhood are aware of adult entertainment material, compared to 73% who never find solicitation.

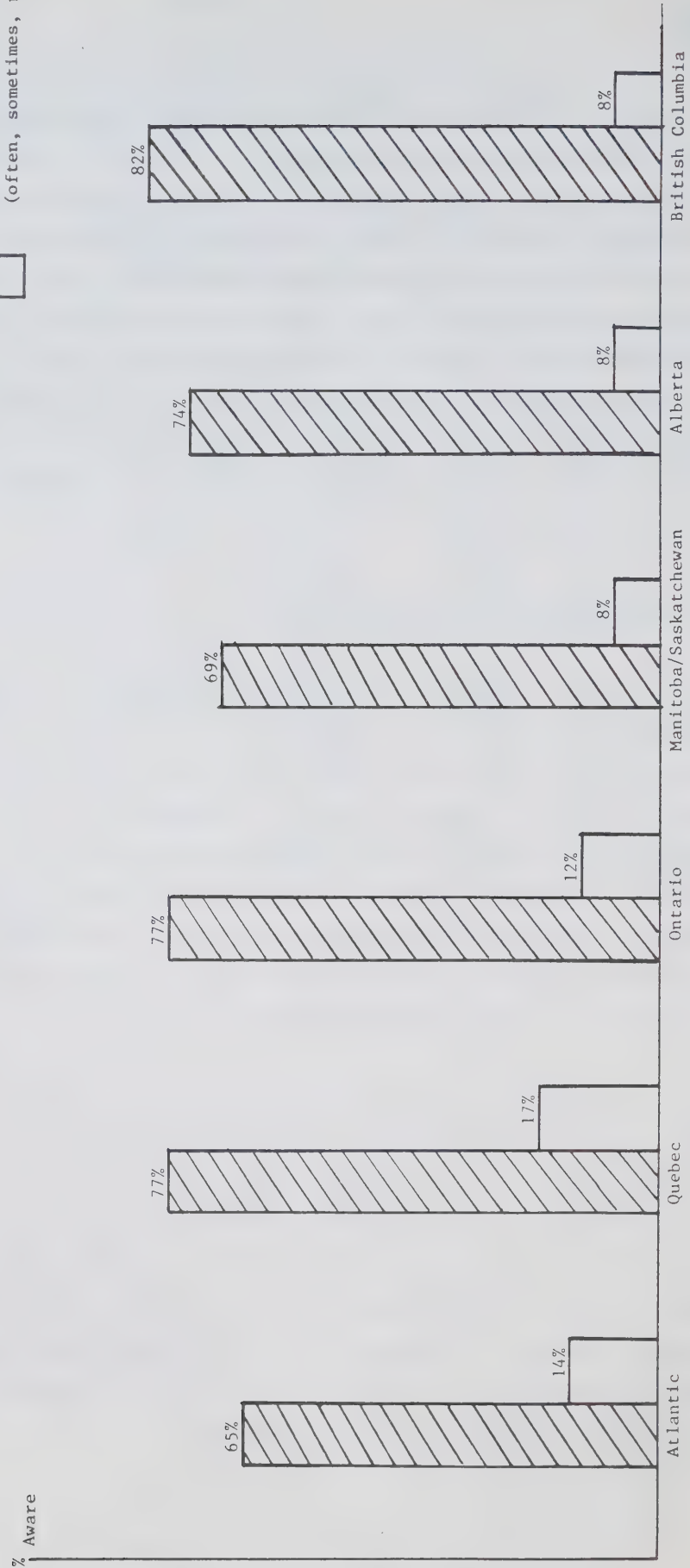
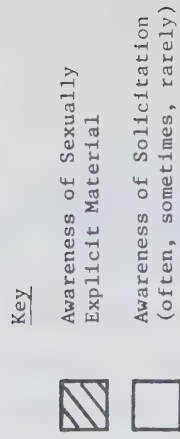
Exposure and Explanatory Variables

There is some commonality in the socio-demographic-economic variables which influence awareness about prostitution activities and pornography. Our earlier analysis showed that respondents' awareness about solicitation activities and the availability of sexual explicit material is related to the province where they reside. Awareness about solicitation in shopping areas was found to be highest in Ontario; however, in residential areas awareness of solicitation was highest in Quebec, the Atlantic and Ontario. Awareness about the availability of sexually explicit material (of a general kind) was found to be lower in the Atlantic than in the other provinces.

Table 12, overleaf, shows the provincial pattern with respect to the awareness about solicitation activities near one's home and the awareness about sexually explicit material. In British Columbia awareness of sexually explicit material is relatively high while awareness of solicitation is relatively low (82% versus 8%). In the Atlantic the reverse is true, with awareness about sexually explicit material relatively low and awareness about solicitation relatively high (65% versus 14% respectively). In Ontario and Quebec, however, we see that residents have a relatively high level of awareness about solicitation activities and sexually explicit material.

TABLE 12

AWARENESS OF SEXUALLY EXPLICIT MATERIAL NEAR ONE'S HOME AND AWARENESS
OF SOLICITATION IN ONE'S RESIDENTIAL AREA BY PROVINCE





The influence of language also has a statistically significant relationship with exposure to both issues. Francophones tend to be more knowledgeable than Anglophones concerning areas where prostitution takes place (other than their residential neighbourhoods and shopping areas) and about the availability of material showing scenes with children.

We found that community size has a statistically significant relationship with awareness about solicitation activities; residents of large communities are more aware of these activities. A statistically significant relationship is not revealed, however, for sexually explicit material and community size. Awareness is more or less similar in communities of all sizes, with the exception of medium-large communities, whose residents are less knowledgeable about such material. Residents of larger communities do appear to be more aware of sexually explicit material showing scenes with children; however, this relationship is not statistically significant.

LEGAL KNOWLEDGE ABOUT PROSTITUTION AND PORNOGRAPHY

Comparison of Aggregate Results

Respondents' awareness of the legalities surrounding prostitution-related activities and sexually explicit material was examined in the preceding chapters. We saw that there is a deficiency in knowledge about the laws surrounding these issues. Most respondents believe that the activities associated with these issues are illegal.

Six activities related to prostitution were presented to the respondents, four of which are illegal, one which is legal and another which is legal under certain circumstances in Canada. We found that most respondents are able to correctly identify the illegal activities but much fewer are able to distinguish the legal activities. While this can be interpreted to mean that respondents are generally knowledgeable about the law and prostitution, the more probable interpretation is that most believe all aspects of prostitution are illegal.



As in the case of prostitution-related activities, it appears that a substantial number of respondents feel that the activities surrounding sexually explicit material are illegal in Canada. Two situations were examined, one of which is legal and the other is illegal. The general belief held by respondents is that both are illegal. There are some respondents who have a knowledge of the facts, but, for the most part, respondents answer incorrectly or indicate that they do not know the legality of the activities.

We found no commonality among the socio-demographic-economic variables related to legal knowledge about both issues.

Legal Knowledge and Consistency

In order to determine whether individual respondents are equally knowledgeable about the facts relating to prostitution and pornography, we compared these two issues in a cross-tabulation. Exhibit 58, overleaf, shows the cross-tabulation of knowledge about the legality of buying an adult's sexual services and the legality of sexually explicit material showing violence, horror or cruelty. The prostitution activity is legal while the pornography issue is illegal.

We see that only 12% of the respondents are knowledgeable about both issues. Most respondents correctly indicate the pornography issue is illegal and incorrectly indicate that the prostitution issue is illegal (46%). This merely confirms the overall findings which show more respondents are aware of the law surrounding the pornography issue but not the prostitution issue (62% compared to 22%).

The Exhibit also shows that respondents who are knowledgeable about the legality of one issue are not necessarily knowledgeable about the legality of the other issue. For example, respondents who correctly indicate that the prostitution issue is legal are less inclined to know that the pornography issue is illegal than those who indicate that the prostitution issue is illegal (53% versus 68%). The converse is also true, i.e., those who correctly

EXHIBIT 58

LEGAL KNOWLEDGE ABOUT
PROSTITUTION AND PORNOGRAPHY

Is buying an adults' sexual services in private,
legal or illegal?

		<u>Legal</u>	<u>Illegal</u>	<u>Missing</u>	<u>Row Total</u>
<u>Is sexually explicit material showing scenes of violence, horror, or cruelty legal or illegal?</u>	Illegal	234	920	92	1246
		18.8%	73.9%	7.3%	100%
		52.7%	67.6%	43.3%	61.8%
		11.6%	45.6%	4.5%	
	Legal	173	338	42	553
		31.3%	61.2%	7.6%	100%
		38.9%	24.8%	19.9%	27.4%
		8.5%	16.7%	2.0%	
	Missing	37	103	79	219
		17.1%	47.4%	35.5%	100%
		8.4%	7.6%	36.8%	10.8%
		1.8%	5.1%	3.9%	
	Column	<u>444</u>	<u>1361</u>	<u>213</u>	<u>2018</u>
		100%	100%	100%	100%
	Total	22.0%	67.5%	10.5%	100.0%

Significance: $p = .0000$

* Row %

** Column %

*** Total %



indicate that the pornography issue is illegal are less inclined to know the prostitution issue is legal than those who indicate that the pornography issue is legal (19% versus 31%).

When we compare knowledge about the legality of buying an adult's sexual services with the legality of sexually explicit material which offends local community standards (not shown), we find a different relationship. Respondents who are knowledgeable about the legality of the prostitution issue tend to be more knowledgeable about the pornography issue than those who are not knowledgeable about the prostitution issue. The reverse is also true.

Hence, the comparison of respondents' knowledge about the laws concerning prostitution and pornography reveals that there is no clear pattern. Knowledge about the law surrounding one issue does not necessarily imply knowledge about the other.

POLICY OPTIONS TO DEAL WITH PROSTITUTION AND PORNOGRAPHY

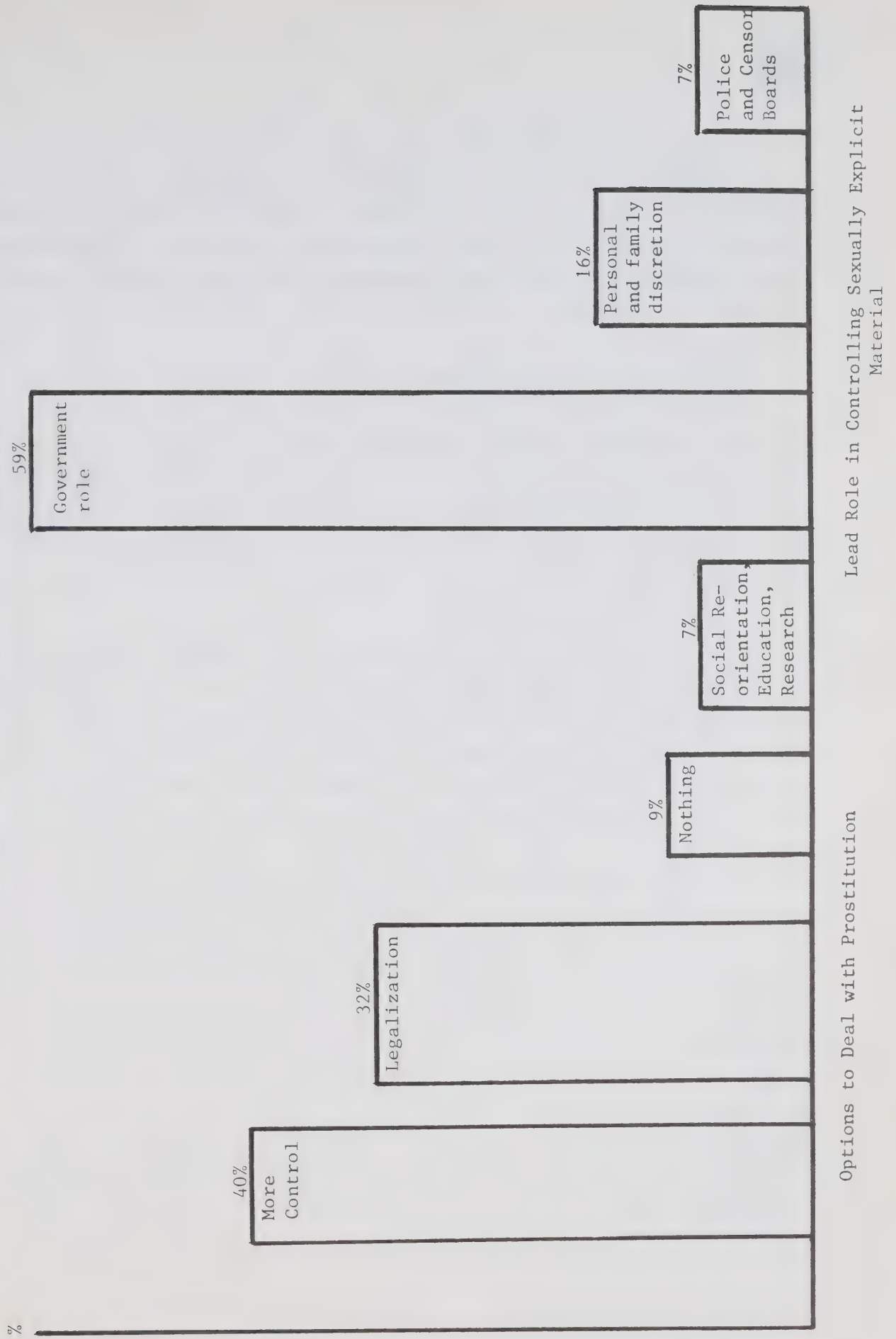
Policy options were examined by reviewing respondents' preferences for the control of prostitution and sexually explicit material and their views regarding the role of the police in the control of these two issues. As well, survey responses with respect to policy options dealing with children were examined. These are described in turn.

Policy Options - General

Comparison of Aggregate Results

The views of respondents concerning policy options to be taken in the control of prostitution and pornography were examined in the preceding chapters. Four major policy options are suggested by respondents to deal with prostitution (street solicitation) and three major groups are identified to take a lead role in controlling sexually explicit material, as shown in Table 13, overleaf. Overall, we see that some type of government role is preferred by a substantial

OPTIONS TO DEAL WITH PROSTITUTION AND SEXUALLY EXPLICIT MATERIAL





number of respondents to deal with sexually explicit material. We also see substantial support for the role of government in dealing with prostitution, since legalization or more control (tougher laws) would certainly require government involvement.

Policy Preferences and Consistency

In order to determine whether respondents propose similar control options to deal with both issues, we compared their views on what they feel should be done about adult prostitution and who should take a lead role in controlling sexually explicit material. The cross-tabulation, shown in Exhibit 59, overleaf, is the result.*

The Exhibit shows that 50% (29.9% + 20%) of the respondents favour an outside role over sexually explicit material (some control) and over prostitution (more control and legalization). Of these respondents, there are more who favour greater control (30%) than legalization (20%) for prostitution. This is consistent with earlier results which indicated more individuals favour greater control over prostitution than legalization (41% compared to 31%).

Some variations occur in how respondents feel the issues should be handled. The most distinct shifts are by those who indicate a preference for more control over prostitution and personal discretion over sexually explicit material and by those who indicate a preference for an outside role in the control of sexually explicit material and a status quo option to deal with prostitution. Approximately 11% of respondents fall into one of two categories.

* For ease of discussion, we grouped respondents preferences for police and censor boards with the preference for a government role and used this as an indicator of outside control over sexually explicit material. We could not determine whether a preference for government role necessarily means more control, although we assumed that those who indicate this option do desire more control than those who indicate personal discretion.

PREFERENCES FOR POLICY OPTIONS TO DEAL WITH SEXUALLY
EXPLICIT MATERIAL AND PROSTITUTION

Who, if any one, do you believe should take the lead role in controlling
sexually explicit material?

	Government/ Police/Censor take lead role	Family and Individuals (Personal Discretion)	Others	Missing	Row Total
More Control	604 29.9%*	120 5.9%	72 3.5%	19 0.9%	824 40.8%
Legalize	404 20.0%	153 7.5%	55 2.7%	28 1.3%	631 31.3%
Nothing	99 4.9%	63 3.1%	15 0.7%	14 0.6%	191 9.4%
Social Reorientation	85 4.2%	30 1.4%	19 0.9%	3 0.1%	136 6.7%
Others	25 1.2%	7 0.3%	1 0.0%	3 0.1%	36 1.8%
Missing	112 5.5%	36 1.7%	13 0.6%	40 1.9%	201 10%
Column Total	1185 65.8%	409 20.2%	174 8.6%	108 5.3%	2018 100%

What do you
think should be
done about
prostitution?

Significance: $p = .0000$

* Total %



As another indicator of consistency in the control option area, we examined respondents' views on the involvement of police to control prostitution (street solicitation) and to control sexually explicit material. Exhibit 60, overleaf, illustrates the cross-tabulation of respondents' answers. The relationship of the two issues is significantly linked ($p = .0000$).

Overall, we see there is support for more power to be held by police to deal with prostitution and pornography. A substantial number of respondents (71% and 66%) indicate similar preferences for the control of prostitution and pornography by police. Fifty-nine percent of respondents who favour more control for prostitution also favour it for sexually explicit material. Three percent of those favouring less control for prostitution advocate less control for pornography. Twelve percent do not favour more nor less control for either issue. Thus, 74% of the respondents indicate the same preferences for both issues.

Looking at shifts, we see that they are not substantial. Only 20% of respondents indicate different preferences for each of the issues and only 4% are extreme shifts (i.e., from less control on one issue to more control on the other).

Policy Options and Explanatory Variables

Our analysis of the explanatory variables influencing what should be done about prostitution and who should take a lead role in the control of sexually explicit material shows there is some commonality between the two issues:

- individuals that favour personal/family discretion in the control of sexually explicit material have similar attributes to individuals who suggest legalization of prostitution. These individuals have a higher tendency to be from Alberta and have wider levels of acceptability toward prostitution and sexually explicit material

EXHIBIT 60

PREFERENCES FOR POWER TO CONTROL ADULT STREET PROSTITUTION
AND SEXUALLY EXPLICIT MATERIAL BY LOCAL POLICE

Do you believe the local police should have much
more or less power to control adult street prostitution?

	<u>More</u>	<u>Neither</u>		<u>Less</u>	<u>Missing</u>	<u>Row</u>
		<u>More</u>	<u>Nor</u>			<u>Total</u>
		<u>Less</u>				
More	1183 58.6%*	100 4.9%	20 1.0%	33 1.5%	1337 66.3%	
Neither	154	249	20	16	439	
More Nor	7.6%	12.3%	1.0%	0.8%	21.8%	
Less	60 2.9%	44 2.1%	63 3.1%	2 0.0%	169 8.3%	
Missing	31 1.5%	13 0.6%	3 0.1%	27 0.7%	73 3.6%	
Column	1428	405	106	78	2018	
Total	70.7%	20.0%	5.2%	3.5%	100%	

Do you believe
that local police should
have much more or less
power to control sexually
explicit material?

Significance: p = .0000
* Total %



- there is some commonality between those that favour personal/family discretion and those that suggest the status quo or social reorientation options. Respondents who suggest these options tend to have fairly wide levels of acceptability toward either prostitution and sexually explicit material
- the proponents of tougher laws to deal with prostitution have similar attributes to those who suggest government should take a lead role to deal with sexually explicit material. Francophones tend to suggest these options more than Anglophones. As well, these respondents tend to have fairly conservative views towards both issues.

Policy Options and Children

Comparison of Aggregate Results

The survey examined policy options dealing with children, either as participants in prostitution or as a potential audience of sexually explicit material. In both cases, there is quite a high level of consensus regarding the need to take actions to protect children.

In the case of child prostitution, the need for government to do more than it is currently doing is expressed by the vast majority of respondents (80%). The actions suggested by respondents support a stricter stand in the way of toughening laws against pimps, customers and even the children themselves. Coupled with the toughening of laws, there is support for increased social service efforts.

In the case of sexually explicit material, respondents are clearly concerned about material where children could be a potential audience or have access to the material. The most appropriate action suggested to deal with this type of material is, however, also very much related to the scene being portrayed and



somewhat by the artistic or educational merit of the material. As a result, a range of actions are suggested, depending on the audience, scene and artistic/educational value of the material in question. We do see, however, that there is considerable support for forbidding children to be sold adult entertainment magazines and for forbidding the presentation of entertainment programs on TV which show nude adults when children might be watching.

Control Options and Consistency

In order to determine whether respondents who suggest controls to deal with child prostitution are the same ones who suggest controls against sexually explicit material which is accessible to children, we compared views on the two issues. Exhibit 61, overleaf, shows the cross-tabulation of responses on whether social service funds should be increased to deal with child prostitution and what should be done about sexually explicit material which is accessible to children. We see that 47% (26.5% and 20.6%) of the respondents believe social service funds should be increased and believe that strong controls should be put in place to protect children against sexually explicit material (forbid it being shown when children might be in the audience and ban the material). Few respondents believe nothing should be done about either issue (1.8%). Another 11% propose nothing should be done about the pornography issue and propose increased social services for child prostitution. An identical proportion propose the converse, i.e., do not propose increased social services for child prostitution and propose some control measure over sexually explicit material which is accessible to children. Thus, 22% of respondents propose distinctly different actions to deal with each issue.

SUMMARY: COMPARISON OF PROSTITUTION AND PORNOGRAPHY ISSUES

The key findings of the foregoing chapter are described below in relation to the five issue areas: public concepts, usage, exposure, legal knowledge and policy options.

EXHIBIT 61

Comparison Of Policy Options To Deal With
Child Prostitution And Sexually Explicit Material
Which Is Accessible To Children

Should the government increase social services
to deal with those involved in child
prostitution?

	<u>YES</u>	<u>NO</u>	<u>MISSING</u>	<u>TOTAL</u>
NOTHING	179 10.9%*	30 1.8%	5 0.3%	214 13.0%
CENSOR	125 7.6%	19 1.1%	7 0.4%	150 9.1%
What do you believe is the most appro- priate thing to do about entertainment programs on TV which show nude adults at hours children might be watching?	FORBID CHILDREN 436 26.5%	61 3.7%	15 1.0%	512 31.2%
	ADVERTISE IT 153 9.3%	34 2.1%	3 0.2%	190 11.6%
	MAY OFFEND			
	FINE OR JAIL 29 1.7%	4 0.2%	-	33.0 2.0%
	BAN THE MATERIAL 338 20.6%	63 3.8%	12 0.8%	413 25.2%
	MISSING 69 4.3%	17 1.2%	42 2.4%	128 7.8%
	<hr/> 1328 80.9%	<hr/> 229 13.9%	<hr/> 84 5.1%	<hr/> 1641 100.0%

*Total % Significance p = .0000



PUBLIC CONCEPTS TOWARD PROSTITUTION AND PORNOGRAPHY

Public concepts were examined by reviewing levels of acceptability toward prostitution and pornography and perceptions about their harms. In regard to the level of acceptability held toward the two issues, we see that:

- A comparison of the aggregate results indicates that the acceptability of the sexual bargaining activities and of sexually explicit material (in general) is quite similar. When the sexually explicit material is defined in the context of a specific scene or audience, a large gap emerges between the two issues. The sexual bargaining activities become more acceptable to the respondents when compared with material showing homosexual intercourse or violent sexual scenes and material which is accessible to children. This is consistent with the results of our conjoint analysis, where these scenes and an audience with children were found to be less acceptable.
- The majority of respondents have consistent views on the issues, i.e., if they find the prostitution issue acceptable, they find the pornography issue acceptable. When there is a shift between the issues it is consistent with the aggregate views held towards them.
- There are common explanatory variables which influence levels of acceptability toward prostitution and pornography. Those who have liberal social sexual attitudes and who are users/consumers tend to have higher levels of acceptability. Exposure, through knowing someone who has given or accepted money for sexual services and through awareness of the availability of sexually explicit material, is positively related to wider acceptability levels.



In relation to public perceptions about the harms of pornography and prostitution, we found that:

- The prevalent thinking among respondents is that prostitution and pornography have harmful effects.
- The most concern is revealed in regard to the harmful effects on children with respect to both issues.
- The majority of respondents have consistent views on the issues. The shifts which occur are consistent with the aggregate views held toward the separate issues.

USE: EXCHANGE OF MONEY FOR SEX AND
CONSUMPTION OF ADULT ENTERTAINMENT

A comparison of prostitution and pornography usage patterns reveals that:

- Consumption of adult entertainment material is much more frequent than is the payment of money in exchange for sexual services. Even the proportion of respondents who consume adult entertainment on all three media (6%) exceeds the proportion who have paid for sexual services.
- Respondents who consume adult entertainment material tend to give money in exchange for sex relatively more often than those who never consume this material. The converse is also true. Respondents who have paid for sexual services tend to consume relatively more sexually explicit material than those who have not paid for sexual services. Most respondents have never consumed adult entertainment (magazines) and have never paid money for sex (54%).
- There are some common explanatory variables which influence use of both prostitution and adult entertainment material. Males and residents of British Columbia tend to be greater consumers of adult entertainment and to have paid in exchange for sex more than others. Respondents with wide acceptability toward various forms of sexually explicit material and toward sexual bargaining tend to consume



relatively more of this material and to have paid money in exchange for sex. Those who are exposed (i.e., aware of the existence of adult entertainment material and know someone who has given money for sex) tend to be consumers of such material and to have given money in exchange for sex.

EXPOSURE TO PROSTITUTION AND PORNOGRAPHY

A comparison of awareness about solicitation and adult entertainment shows that:

- There appears to be much more widespread awareness about the availability of adult entertainment than about solicitation activities.
- Because awareness about adult entertainment material is so much more widespread compared to solicitation, it is not surprising that most respondents (54%) tend to be aware of adult entertainment but not of solicitation near their homes. Only 10% are aware of both adult entertainment and solicitation and a similar proportion are unaware of both of these near their homes.
- Awareness about adult entertainment material implies awareness about solicitation. The reverse is also true; respondents who are aware of solicitation near their homes are more inclined to see adult entertainment in their residential neighbourhood.
- Awareness about solicitation and adult entertainment appears to be higher in specific provinces. Ontario residents tend to have the highest awareness about solicitation in residential areas. Awareness about adult entertainment is lowest in the Atlantic provinces.
- Provinces where there is the most awareness about solicitation activities are not necessarily the same as the provinces where the awareness about sexually explicit material is the highest. The exceptions are Ontario and Quebec where awareness is relatively high about both solicitation and adult entertainment material.



- Awareness about solicitation is more frequent in larger cities, while awareness about sexually explicit material is fairly similar across different size communities.
- Francophones, more than Anglophones, tend to know other areas where prostitution takes place and about the availability of adult entertainment material showing scenes with children.

LEGAL KNOWLEDGE ABOUT PROSTITUTION AND PORNOGRAPHY

A comparison of the respondents' awareness of the law surrounding prostitution-related activities and sexually explicit material indicate that:

- Overall, there is not a great deal of knowledge about the laws surrounding prostitution and pornography. Most respondents believe that the activities surrounding these issues are illegal.
- Few respondents (12%) are knowledgeable about the laws surrounding both issues in the case we compared.
- There does not appear to be a clear pattern between the respondents' knowledge about the legalities of prostitution and their knowledge about the legalities of pornography, i.e., knowledge about one issue does not always imply knowledge about the other issue.

POLICY OPTIONS TO DEAL WITH PROSTITUTION AND PORNOGRAPHY

A comparison of the policy options to be taken to deal with prostitution and pornography indicates that:

- Some type of government role is preferred by a substantial number of respondents to deal with prostitution and sexually explicit material.
- Most respondents (50%) favour an outside role (some control) over sexually explicit material and also desire this for prostitution (more control and legalization).



- The requirement for more police power to control prostitution and sexually explicit material is favoured by many (71% and 66%, respectively).
- A substantial number of respondents (73%) indicate the same preferences for police control over both issues and only 4% indicate preferences which differ distinctly. A total of 59% of respondents indicate the requirement for more control by police to deal with prostitution and pornography.
- In a comparison of the explanatory variables influencing both issues, we see that individuals who favour personal/family discretion in the control of sexually explicit material have similarly wide levels of acceptability to those who favour the legalization, status quo or social reorientation options to deal with prostitution.
- Proponents of tougher laws to deal with prostitution have fairly conservative levels of acceptability as do those who suggest government should take a lead role to deal with sexually explicit material.
- There is quite a high level of consensus regarding the need to take strict actions with respect to child prostitution and sexually explicit material which is accessible to children.
- Most respondents who favour an increased role for government in dealing with child prostitution also favour controls to protect children from sexually explicit material. Only 22% of respondents propose distinctly different actions to deal with each issue.

A NATIONAL POPULATION STUDY
OF
PROSTITUTION AND PORNOGRAPHY

APPENDICES

Peat, Marwick & Partners

October 22, 1984



APPENDIX A

SURVEY INSTRUMENTS

- OMNIBUS QUESTIONNAIRE
- BOOKLET QUESTIONNAIRE

1A. In your opinion, what is the most important social problem facing Canadians today (other than either unemployment or inflation)?

PROBE

(35) (36)

READ

The next section of this survey has been commissioned by the department of justice in its efforts to better understand public standards on matters relating to prostitution and pornography. We realize that these are sensitive topics for many people. We assure you, however that all of your answers will remain strictly confidential.

49.Aa) Would you say that sex between two adults in exchange for money is prostitution?

(61)

yes	1
no.	2
it depends (sometimes).	3
don't know.	9
refusal/no answer	0

b) Using this card, please tell me how morally acceptable you consider this type of behaviour to be (the exchange of sexual services for money)?

(62)

HAND RESPONDENT
CARD "A"

acceptable in all cases	1
acceptable in most cases.	2
acceptable only in some cases	3
unacceptable in most cases.	4
unacceptable in all cases	5
it depends (sometimes).	6
don't know.	9
refusal/no answer	0

50.Aa) Would you say that sex between two adults which is exchanged for something other than money such as dinner, a gift, or a vacation is prostitution?

(63)

yes	1
no.	2
it depends (sometimes).	3
don't know.	9
refusal/no answer	0

b) How morally acceptable do you consider this type of behaviour (the exchange of sexual services for something other than money)?

(64)

HAND RESPONDENT
CARD "A"

acceptable in all cases	1
acceptable in most cases.	2
acceptable only in some cases	3
unacceptable in most cases.	4
unacceptable in all cases	5
it depends (sometimes).	6
don't know.	9
refusal/no answer	0



51.A Why do you think prostitution occurs?

☐ PROBE _____

(65) (66)

☐ ☐

52.A What persons, if any, are the most responsible for acts of adult prostitution?

(67)

☐ DO NOT READ

prostitutes 1

customers or clients. 2

intermediaries (example: pimps, madames). 3

none. 4

other: 5

(specify) _____

don't know. 9

refusal/no answer 0

53.A Please tell me how acceptable you find each of the following for entertainment purposes:

☐ HAND RESPONDENT
CARD "A"

☐ ROTATE

	Acceptable			Unacceptable				
	In all cases	In most cases	Only in some cases	In most cases	In all cases	It depends	Don't know	Refusal/no answer

() Sexual intercourse between a man and a woman, as shown on late-night TV.	1	2	3	4	5	6	9	0	(68)
() Magazines showing sexual intercourse between two adults of the same sex	1	2	3	4	5	6	9	0	(69)
() TV programs showing nude adults at times when children might be watching	1	2	3	4	5	6	9	0	(70)
() Adult-only restricted movies with violent sexual scenes.	1	2	3	4	5	6	9	0	(71)
() Magazines which could be available at your local store or newstand, which show pictures of nude women.	1	2	3	4	5	6	9	0	(72)

54.A How often, if ever, have you seen entertainment programs on TV showing nude adults in the last 12 months?

(73)

never 1

once. 2

2 - 5 times 3

6 - 15 times. 4

16 - 25 times 5

26 - 50 times 6

more than 50 times. 7

don't know. 9

refusal/no answer 0



55.Aa) How many adult entertainment magazines, if any, have you bought in the last 12 months?

none.
one
2 - 5
6 - 15.
16 - 25
26 - 50
more than 50.
don't know.
refusal/no answer

(74)
1 GO TO 1.55.c)
2
3
4
5
6
7
9 GO TO
0 1.55.

b) What was the title of the one you bought most often?

DO NOT READ

Forum
Hustler
Lui
Mandate
Penthouse
Playboy
Playgirl.
other: _____
(specify)
don't know.
refusal/no answer

(75)(76)
01
02
03
04
05
06
07
08
98
99

c) How many adult entertainment magazines, if any, have you read or leafed through in the last 12 months not counting any you may have bought?

none.
one
2 - 5
6 - 15.
16 - 25
26 - 50
more than 50.
don't know.
refusal/no answer

(77)
1 GO TO 1.56.f
2
3
4
5
6
7
9 GO TO
0 1.56.f

d) What was the title of the one you read or leafed through most often?

DO NOT READ

Forum
Hustler
Lui
Mandate
Penthouse
Playboy
Playgirl.
other: _____
(specify)
don't know.
refusal/no answer

(78)(79)
01
02
03
04
05
06
07
08
98
99



56.A	How many adult-only video cassettes, if any, have you bought or rented in the last 12 months?	(10)
	none.	1
	one	2
	2 - 5	3
	6 - 15.	4
	16 - 25	5
	26 - 50	6
	more than 50.	7
	don't know.	9
	refusal/no answer	0

57.A To the best of your knowledge, are the following kinds of sexually explicit materials available near your home?

READ

	Yes	No	Don't know	Refusal/ no answer	
a) "adult entertainment" magazines, videos, <u>or</u> movies	1	2	9	0	(11)
b) magazines, videos <u>or</u> movies showing sexually explicit scenes with violence.	1	2	9	0	(12)
c) magazines, videos <u>or</u> movies showing sexually explicit scenes with children.	1	2	9	0	(13)

58.A Would you be offended if you saw any of these materials in a store near your home? (14)

yes	1
yes (qualified): _____ (specify)	2
no.	3
no (qualified): _____ (specify)	4
don't know.	9
refusal/no answer	0

59.A Using this card, please tell me the extent to which you agree or disagree with each of the following statements:

HAND RESPONDENT
CARD "B"

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	It depends	Don't know	Refusal/ no answer	
a) Sex magazines are unacceptable in our society	1	2	3	4	5	6	9	0	(15)
b) Sex magazines are degrading to women.	1	2	3	4	5	6	9	0	(16)
c) Violent sexual material leads readers or viewers to commit acts of violence.	1	2	3	4	5	6	9	0	(17)
d) Sexually explicit material showing children is unacceptable in our society	1	2	3	4	5	6	9	0	(18)



60.A To the best of your knowledge, are the following legal or illegal?

	<u>Legal</u>	<u>Illegal</u>	<u>Don't know</u>	<u>Refusal/no answer</u>	
a) Sexually explicit material showing scenes of violence, horror or cruelty	1	2	9	0	(19)
b) Any sexually explicit material.	1	2	9	0	(20)
c) Sexually explicit material which offends your local community standards	1	2	9	0	(21)

61.A Who, if anyone, **do** you believe should take the lead role in controlling sexually explicit material? (22)(23)

☐ DO NOT READ

☐ ONE ANSWER ONLY

- no one.	01
- governments (unspecified)	02
- federal government.	03
- provincial government	04
- municipal government.	05
- individuals	06
- family.	07
- pornography industry itself	08
- police.	09
- censor boards	10
- customs	11
- the church.	12
other: _____	13
(specify)	
don't know.	99
refusal/no answer	00

62.A Do you believe that local police should have much more, more, less or much less power to control offensive sexually explicit material? (24)

much more	1
more.	2
neither more nor less	3
less.	4
much less	5
don't know.	9
refusal/no answer	0

63.A Do you believe that censor boards should have much more, more, less or much less power to control sexually explicit material? (25)

much more	1
more.	2
neither more nor less	3
less.	4
much less	5
don't know.	9
refusal/no answer	0



64.A. How often, if at all, does solicitation for the purposes of prostitution take place on the streets of your residential neighbourhood? Is it ... (26)

<input type="checkbox"/> READ	often	1
	sometimes	2
	rarely.	3
	or never?.	4
	<input type="checkbox"/> don't know.	9
	<input type="checkbox"/> refusal/no answer.	0

65.A How often, if at all, does solicitation for the purposes of prostitution take place on the streets in the area where you normally do your grocery shopping? Is it ... (27)

<input type="checkbox"/> READ	often	1
	sometimes	2
	rarely.	3
	or never?.	4
	<input type="checkbox"/> don't know.	9
	<input type="checkbox"/> refusal/no answer.	0

66.A Except for solicitation on the streets, are you aware of any other areas in your municipality where prostitution takes place? If so, where? (28)(29)

<input type="checkbox"/> DO NOT READ	no.	01
	yes: - shopping centers.	02
	- parks	03
	- cars.	04
	- bars/hotels/motels.	05
	- massage parlors or steam baths. .	06
	- call girl apartments.	07
	- bawdy houses/ brothels/whorehouse	08
	- other: _____	09
	(specify)	
	don't know.	99
	refusal/no answer	00

☐ READ: Please read the question on this card and tell me the code that corresponds to your answer.

☐ HAND RESPONDENT CARD "C". DO NOT READ QUESTION.

67.A Have you ever accepted money in exchange for sex?

	Q.67.A (30)	Q.68.A (31)
- yes → How many times? - once.	1	1
- 2 - 5 times . . .	2	2
- 6 - 20 times. . .	3	3
- 21 times or more. .	4	4
- don't remember. .	5	5
- refuse to say how many times. .	6	6
- no.	7	7
don't know.	9	9
refusal to answer	0	0

☐ HAND RESPONDENT CARD "D". DO NOT READ QUESTION.

68.A Have you ever given money in exchange for sex?



69.A Do you, personally, know anyone who has accepted money in exchange for sex? (32)

yes 1
no. 2
don't know. 9
refusal/no answer 0

70.A Do you, personally, know anyone who has given money in exchange for sex? (33)

yes 1
no. 2
don't know. 9
refusal/no answer 0

71.A To what extent do you agree or disagree with the following opinions:

HAND RESPONDENT
CARD "B"

Strongly
agree
Somewhat
agree
Neither
agree nor
disagree
Somewhat
disagree
Strongly
disagree
It
depends
Don't
know
Refusal/
no answer

a) Prostitution will always exist no matter what we do . . 1 2 3 4 5 6 9 0 (34)

b) Prostitution is a major cause in the spread of venereal disease 1 2 3 4 5 6 9 0 (35)

72.A Does visible solicitation of passers-by by prostitutes offend you very much, somewhat, not much or not at all?

	Q. 72.A (36)	Q. 73.A (37)
very much	1	1
somewhat.	2	2
not much.	3	3
not at all.	4	4
don't know.	9	9
refusal/no answer	0	0

73.A And does visible solicitation of passers-by by men looking for a prostitute offend you very much, somewhat, not much or not at all?



74.A To the best of your knowledge, are the following activities legal or illegal in Canada today?

	<u>Legal</u>	<u>Illegal</u>	<u>Don't know</u>	<u>Refusal/no answer</u>	
a) The buying of an adult's sexual services in private?	1	2	9	0	(38)
b) An adult selling his or her own sexual services in a brothel?	1	2	9	0	(39)
c) Pressing or persistent solicitation for the purposes of prostitution?	1	2	9	0	(40)
d) An adult buying the sexual services of children?	1	2	9	0	(41)
e) An adult arranging for the prostitution of children?	1	2	9	0	(42)
f) An adult arranging for the prostitution of other adults?	1	2	9	0	(43)

75.A Do you believe that the legal system deals adequately with prostitution at this time? (44)

yes	1
no.	2
don't know.	9
refusal/no answer	0

76.A What do you think should be done about prostitution?

PROBE _____

(45) (46)

77.A Should the local police have much more, more, less or much less power to control adult street prostitution? (47)

much more	1
more.	2
neither more nor less	3
less.	4
much less	5
don't know.	9
refusal/no answer	0

SOCIO-DEMOGRAPHIC QUESTIONS

☐ ALL

☐ READ Now, I would like to get some information to help us group your answers with others which we will receive in this survey...

A. Which of the following best describes your own present employment status? (66)

<input type="checkbox"/> READ	working full-time.	1	
	working part-time.	2	
	unemployed or looking for a job.	3	
	stay at home full-time	4	} GO TO Q.C
	student.	5	
	retired.	6	
	<input type="checkbox"/> refusal.	0	

☐ IF "WORKING FULL-TIME", "WORKING PART-TIME" OR "UNEMPLOYED" ASK:

B. What is your principal occupation? (SPECIFY THE TYPE OF OCCUPATION) (67)

_____	1
_____	2
_____	3
_____	4
_____	5
_____	6
_____	7
_____	8
_____	9
_____	0
_____	M

FOR OFFICE USE ONLY
DO NOT WRITE

C. Do you, or does anyone in your household belong to a labour union? (68)

<input type="checkbox"/> SPECIFY	respondent belongs to union.	1
	other household member belongs to union . .	2
	no one belongs to union.	3
	don't know/no answer	9
	<input type="checkbox"/> refusal.	0

D. What is your religious affiliation, if any? (69)

<input type="checkbox"/> SPECIFY	Catholic (Roman)	1
	Protestant (United, Anglican, Presbyte- rian, Baptist, Mennonite, Jehovah Wit- ness, Adventist, etc.)	2
	Jewish	3
	other: _____ (specify)	4
	none	5
	<input type="checkbox"/> refusal.	0



E. How many years of schooling have you completed?

(70)

HAND RESPONDENT
CARD "E"

none.	1
1 to 2 years.	2
3 to 4 years.	3
5 to 6 years.	4
7 to 8 years.	5
9 to 10 years.	6
11 to 13 years.	7
14 to 16 years.	8
17 years or more.	9
refusal.	0

F. Are you:

(71)

READ

married or equivalent.	1
single.	2
widowed.	3
separated.	4
or divorced?	5
refusal.	0

G. Which number on this card best corresponds to the total annual income, before taxes, of all members of your household?

(72)

HAND RESPONDENT
CARD "F"

under \$10,000.	1
\$10,000 to \$14,999.	2
\$15,000 to \$19,999.	3
\$20,000 to \$24,999.	4
\$25,000 to \$29,999.	5
\$30,000 to \$34,999.	6
\$35,000 to \$49,999.	7
\$50,000 and over.	8

IF "REFUSED/DON'T
KNOW" CODE YOUR
ESTIMATE BELOW.

1, 2, 3, 4, 5, 6, 7, 8

(73)

H. Which language do you, yourself, usually speak at home. (If you speak more than one language, which one do you speak most often?)

(74)

INSIST ON ONLY
ONE ANSWER

DO NOT READ

French.	1
English.	2
other: _____ (specify)	3
refusal.	0

I. Are you able to carry on a conversation:

(75)

READ

ONE ANSWER ONLY

- only in English.	1
- only in French.	2
<u>or</u> both in English <u>and</u> in French?.	3



J. Language of this interview:

(76)

French 1

English 2

FOR RESPONDENTS IN THE MONTREAL REGION ONLY

K. Our company conducts another kind of research which is called "focus group interview sessions". At these sessions, ten participants are invited to give their opinions and discuss current topics. Participants receive \$20 to cover their travel expenses. Would you be interested in participating in such a group interview session should the occasion arise?

(77)

DO NOT READ

yes 1

no. 2

it depends. 3

don't know/no answer. 9

THANK RESPONDENT FOR HIS/HER COOPERATION AND OBTAIN BASIC INFORMATION ON COVER PAGE.





PROJECT NUMBER:

1	2	3	0
(1)	(2)	(3)	(4)

OFFICE USE ONLY:

(5)	(6)	(7)	(8)

USE THESE BOXES TO
SHOW THE NUMBER ON
THE LAST PAGE OF
THE REPORT

--	--	--	--

Dear Sir,
Dear Madam,

Thank you for receiving our interviewer and for agreeing to fill out this second questionnaire. This particular questionnaire has been commissioned by the Department of Justice in its pursuit to better understand public standards on matters relating to pornography and prostitution.

We understand that these are sensitive topics for many people; this booklet is designed to avoid any embarrassment and to preserve confidentiality.

This is not a contest, and in most cases, there is no such thing as a right or wrong answer. Simply read each question in turn and then circle the number for the answer which comes closest to your opinion.

Please be assured that your anonymity is guaranteed, and we will, of course, treat all information as strictly confidential.

Let me say again how much we appreciate your co-operation.

Yours truly,

Véronique Dorison
Field Director

VD/sb

1. First of all, you will find below, a series of statements. Show how acceptable you feel the situation described in each one is, by circling the number corresponding to your opinion.

			Neither acceptable nor unacceptable		
	Completely acceptable	Somewhat acceptable		Somewhat unacceptable	Completely unacceptable

1
(9)

Example:

A baby eating ice cream with its hands. . . .	1	2	3	④	5
---	---	---	---	---	---

-
- | | | | | | | |
|---|---|---|---|---|---|------|
| a) Exchanging sex
for money. . . . | 1 | 2 | 3 | 4 | 5 | (10) |
| b) Seeing a fight
between the play-
ers at a profes-
sional hockey
game | 1 | 2 | 3 | 4 | 5 | (11) |
| c) Buying sexually
explicit maga-
zines for private
use. | 1 | 2 | 3 | 4 | 5 | (12) |
| d) Men who make
their living by
playing football | 1 | 2 | 3 | 4 | 5 | (13) |
| e) Exchanging dinner
for sex. | 1 | 2 | 3 | 4 | 5 | (14) |
| f) Women who make
their living by
posing nude for
magazines. . . . | 1 | 2 | 3 | 4 | 5 | (15) |
| g) The use of pretty
girls in adver-
tising for com-
mercial products
such as cars or
soft drinks. . . | 1 | 2 | 3 | 4 | 5 | (16) |



2. At what age would you say that you first saw a picture of a nude adult?
Circle the number corresponding to your answer.

(17)

- under 4 years old 1
- 4 - 10 years. 2
- 11 - 15 years 3
- 16 - 20 years 4
- 21 - 25 years 5
- 26 - 30 years 6
- over 30 years 7
- never 8
- don't remember. 9

3. At what age did you first see a nude adult? Again circle the number corresponding to your answer.

(18)

- under 4 years old 1
- 4 - 10 years. 2
- 11 - 15 years 3
- 16 - 20 years 4
- 21 - 25 years 5
- 26 - 30 years 6
- over 30 years 7
- never 8
- don't remember. 9

4. Could you easily find or see the following in the area where you live?

FOR EACH ITEM, CIRCLE (1) IF YOUR ANSWER IS YES, CIRCLE (2) IF YOUR ANSWER IS NO, CIRCLE (9) IF YOU DON'T KNOW.

- | | <u>Yes</u> | <u>No</u> | <u>Don't know</u> | |
|--|------------|-----------|-------------------|------|
| a) Magazines showing nude adults. | 1 | 2 | 9 | (19) |
| b) Live strip show bars | 1 | 2 | 9 | (20) |
| c) Video cassettes featuring sexual acts
between adults | 1 | 2 | 9 | (21) |
| d) TV movies showing nude adults. | 1 | 2 | 9 | (22) |
| e) Theatres showing movies with explicit
sexual acts between adults | 1 | 2 | 9 | (23) |
| f) Material showing violent sexual acts | 1 | 2 | 9 | (24) |
| g) Material showing children involved in
explicit sexual acts | 1 | 2 | 9 | (25) |

5. Below is a list of opinions. For each one, show the extent to which you agree or disagree by circling the number corresponding best to your opinion.

Agree Agree Neither
strongly somewhat agree nor Disagree Disagree
 disagree somewhat strongly

Example:

Whistling is a bad habit . . . 1 2 3 ④ 5

- | | | | | | | |
|--|---|---|---|---|---|------|
| a) Pornography is not a problem in Canada today. | 1 | 2 | 3 | 4 | 5 | (26) |
| b) Violent sexual material shown in magazines or movies leads to increased violence against women. | 1 | 2 | 3 | 4 | 5 | (27) |
| c) The availability of sex magazines in areas frequented by children is bad for the children | 1 | 2 | 3 | 4 | 5 | (28) |
| d) It is better for people to obtain sexually explicit material through mail-orders than from local stores | 1 | 2 | 3 | 4 | 5 | (29) |
| e) One can easily see pornography on TV these days | 1 | 2 | 3 | 4 | 5 | (30) |
| f) Sexually explicit materials become unacceptable only when violence is shown. | 1 | 2 | 3 | 4 | 5 | (31) |
| g) Exposure to pornography can help children to develop healthy sexual attitudes | 1 | 2 | 3 | 4 | 5 | (32) |
| h) Sexually explicit material is degrading to women. | 1 | 2 | 3 | 4 | 5 | (33) |
| i) Women are portrayed in a more degrading fashion than men in sexually explicit material | 1 | 2 | 3 | 4 | 5 | (34) |
| j) Everyone has the right to view sexually explicit material as long as it is done in private. | 1 | 2 | 3 | 4 | 5 | (35) |
| k) Pornography is a problem only when it is accessible to children | 1 | 2 | 3 | 4 | 5 | (36) |

	<u>Agree</u> <u>strongly</u>	<u>Agree</u> <u>somewhat</u>	<u>Neither</u> <u>agree nor</u> <u>disagree</u>	<u>Disagree</u> <u>somewhat</u>	<u>Disagree</u> <u>strongly</u>	
l) Everyone has the right to produce sexually explicit materials so long as it does not hurt anyone	1	2	3	4	5	(37)
m) Pornography that shows violence as a part of sexual activity is unacceptable to me.	1	2	3	4	5	(38)
n) Use of sexually explicit materials by adults is acceptable	1	2	3	4	5	(39)
o) Pornography is degrading to men	1	2	3	4	5	(40)
p) Pornography is easily available to everyone. . . .	1	2	3	4	5	(41)
q) Sexually explicit material can be a safe outlet for aggressive sexual behaviour.	1	2	3	4	5	(42)
r) Sexually explicit material contributes to pleasurable sexual experiences	1	2	3	4	5	(43)
s) All sexually explicit material for adult entertainment is obscene.	1	2	3	4	5	(44)
t) Violent pornographic scenes are imitated by people in real life.	1	2	3	4	5	(45)



6. The following table asks you how acceptable you feel it would be to see different people or scenes in each of a series of places. For example: how acceptable do you feel it is to see a street walker in an open public place? Put the number corresponding to your answer in the appropriate box. Please put one answer in each of the sixteen boxes.

Possible answers:

- 1 = Completely acceptable
- 2 = Somewhat acceptable
- 3 = Neither acceptable nor unacceptable
- 4 = Somewhat unacceptable
- 5 = Completely unacceptable

	Open public place (e.g. a park)	Partially visible public place (e.g. a car in a parking lot)	Private place such as a private apartment	Private commercial place such as a massage parlor
--	---------------------------------------	---	--	---

Example:

A baby eating ice cream with its hands .	<input type="text" value="4"/>	<input type="text" value="2"/>	<input type="text" value="2"/>	<input type="text" value="5"/>
---	--------------------------------	--------------------------------	--------------------------------	--------------------------------

a) Street walkers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Prostitutes other than street walkers (example: call girls).	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Bargaining which takes place between prostitute and client	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Prostitution sexual services such as sexual intercourse.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(46)(47)(48)

(50)(51)(52)

(54)(55)(56)

(58)(59)(60)

7. Here again is a series of opinions. Please show how much you agree or disagree with each opinion by circling the number corresponding to your opinion.

	Agree <u>strongly</u>	Agree <u>somewhat</u>	Neither agree nor <u>disagree</u>	Disagree <u>somewhat</u>	Disagree <u>strongly</u>
--	--------------------------	--------------------------	---	-----------------------------	-----------------------------

Example:

It is best to look on the bright side of things. . . .	1	2	③	4	5
---	---	---	---	---	---

-
- | | | | | | | |
|--|---|---|---|---|---|------|
| a) Prostitutes make a lot of
money. | 1 | 2 | 3 | 4 | 5 | (62) |
| b) Prostitution in residential
areas has no effect on
residential property values. | 1 | 2 | 3 | 4 | 5 | (63) |
| c) Prostitution in my neighbour-
hood is now more visible than
ever before. | 1 | 2 | 3 | 4 | 5 | (64) |
| d) Prostitution is linked to
organized crime. | 1 | 2 | 3 | 4 | 5 | (65) |
| e) Prostitution is degrading
to prostitutes | 1 | 2 | 3 | 4 | 5 | (66) |
| f) Violence rarely accompanies
prostitution | 1 | 2 | 3 | 4 | 5 | (67) |
| g) Street solicitation in areas
where there are children is
bad for the children | 1 | 2 | 3 | 4 | 5 | (68) |
| h) Women become prostitutes
because of economic in-
equalities | 1 | 2 | 3 | 4 | 5 | (69) |
| i) Prostitution is not degrad-
ing to clients | 1 | 2 | 3 | 4 | 5 | (70) |
| j) Street solicitation in
residential neighbourhoods
causes traffic congestion
and noise. | 1 | 2 | 3 | 4 | 5 | (71) |
| k) Most prostitutes are
controlled by pimps. | 1 | 2 | 3 | 4 | 5 | (72) |
| l) In areas where there are no
children, prostitution is
not a problem. | 1 | 2 | 3 | 4 | 5 | (73) |
| m) Juveniles resort to prosti-
tution because they can't
find jobs. | 1 | 2 | 3 | 4 | 5 | (74) |

8. At what level, if at all, should sex education be started in schools?

(75)

- never 1
- primary school 2
- secondary (high) school 3
- college/university 4

9. What do you think the government should do about adult prostitution? For each statement below, circle (1) if you think that the government should do it and (2) if you think the government should not do it. Should the government ...

	<u>Yes, should</u>	<u>No, should not</u>	
a) increase social services to deal with those who are involved in prostitution	1	2	(76)
b) do nothing more than it is doing now.	1	2	(77)
c) create zoning laws to restrict prostitution activities to specific areas of cities	1	2	(10)
d) leave prostitutes alone but prosecute customers.	1	2	(11)
e) leave prostitutes alone but prosecute pimps.	1	2	(12)
f) require prostitutes to have licenses	1	2	(13)
g) require prostitutes to have medical examinations	1	2	(14)
h) make the law tougher against prostitutes.	1	2	(15)
i) decriminalize prostitution-related activities	1	2	(16)
j) other: _____			
_____	1	2	(17)
(specify)			



10. To what extent do you agree or disagree with each of the following opinions. Circle the number corresponding to your answer.

	Agree <u>strongly</u>	Agree <u>somewhat</u>	Neither agree nor <u>disagree</u>	Disagree <u>somewhat</u>	Disagree <u>strongly</u>	
a) A homosexual would be as acceptable a school teacher as anyone else	1	2	3	4	5	(18)
b) A woman must have higher sexual morals than a man . .	1	2	3	4	5	(19)
c) The law should enforce sexual morals which agree with my own.	1	2	3	4	5	(20)
d) Men are better executives than women	1	2	3	4	5	(21)
e) A person should be able to do anything as long as it doesn't harm others.	1	2	3	4	5	(22)
f) A person who runs nude across a public place (a "streaker") is simply amusing.	1	2	3	4	5	(23)

11. Do you believe that any of the following should be allowed to operate?

	<u>Yes</u>	<u>No</u>	
a) Street solicitation for the purposes of prostitution.	1	2	(24)
b) Brothels	1	2	(25)
c) All forms of prostitution, but only in designated areas of town.	1	2	(26)
d) Prostitution on private premises . . .	1	2	(27)
e) Escort and call-girl services.	1	2	(28)



12. What do you think government should do about child prostitution? Should the government ...

	<u>Yes</u>	<u>No</u>	
a) increase social services to deal with those who are involved in such prostitution	1	2	(29)
b) do nothing more than what is being done now	1	2	(30)
c) toughen laws against the child prostitution pimps	1	2	(31)
d) toughen law against the customers. . .	1	2	(32)
e) toughen laws against the children. . .	1	2	(33)
f) other: _____			
(specify) _____	1	2	(34)

13a). Have you ever been a victim of a sexual offense? (35)

yes 1
no. 2 - GO TO Q.14

b). At what age did this happen? (If it has happened to you more than once, how old were you the first time?) (36)

under 4 years old 1
4 - 10 years. 2
11 - 15 years 3
16 - 20 years 4
21 - 25 years 5
26 - 30 years 6
more than 30 years. 7



4. This next section asks you about the acceptability of scenes which may appear on TV, or in magazines or movies.

Let's start with entertainment shows on TV

In column #1 of the table below, please indicate the number of times you have seen each of the scenes listed below during the last twelve months. If you have not seen it, please enter 0. If you are uncertain, please make your best estimate.

In columns #2, 3 and 4, please circle the number which is your best answer to the following questions.

Column #2 How acceptable do you consider this to be for viewing yourself?

Column #3 How acceptable do you consider this to be for viewing by other adults?

Column #4 How acceptable do you consider this to be for viewing by children?

Circle the 1 if you find it completely acceptable

2 if you find it acceptable in most cases

3 if you find it acceptable in some cases

4 if you find it unacceptable in most cases

5 if you find it completely unacceptable

(37)(38)

(39)(40)(41)

(42)(43)

ENTERTAINMENT SHOWS ON TV

(44)(45)(46)

(47)(48)

(49)(50)(51)

(52)(53)

(54)(55)(56)

(57)(58)

(59)(60)(61)

Scenes on TV entertainment shows showing:	Column #1	Column #2	Column #3	Column #4
	No of times I've seen it in last 12 months	Acceptability for viewing myself	Acceptability for viewing by other adults	Acceptability for viewing by children
Example: Baby eating ice cream with its hands	8	① 2 3 4 5	1 ② 3 4 5	1 2 3 4 ⑤
A. One or more nude women		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
B. Two adults of the same sex engaged in sex- ual intercourse		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C. Sex combined with violence		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
D. One or more nude men		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
E. A man and a woman engaged in sexual inter-		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5



15. Now let's discuss entertainment magazines

In column #1 of the table below, please indicate the number of times you have seen each of the scenes listed below during the last twelve months. If you have not seen it, please enter 0. If you are uncertain, please make your best estimate.

In columns #2, 3 and 4, please circle the number which is your best answer to the following questions.

Column #2 How acceptable do you consider this to be for viewing yourself?

Column #3 How acceptable do you consider this to be for viewing by other adults?

Column #4 How acceptable do you consider this to be for viewing by children?

- Circle the
- 1 if you find it completely acceptable
 - 2 if you find it acceptable in most cases
 - 3 if you find it acceptable in some cases
 - 4 if you find it unacceptable in most cases
 - 5 if you find it completely unacceptable

ENTERTAINMENT MAGAZINES

Scenes in entertainment magazines showing:	Column #1	Column #2	Column #3	Column #4
	No of times I've seen it in last 12 months	Acceptability for viewing myself	Acceptability for viewing by other adults	Acceptability for viewing by children
<u>Example:</u> Baby eating ice cream with its hands	<u>8</u>	① 2 3 4 5	1 ② 3 4 5	1 2 3 4 ⑤
A. One or more nude women	<u> </u>	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
B. Two adults of the same sex engaged in sexual intercourse	<u> </u>	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C. Sex combined with violence	<u> </u>	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
D. One or more nude men	<u> </u>	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
E. A man and a woman engaged in sexual intercourse	<u> </u>	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

(62)(63)

(64)(65)(66)

(67)(68)

(69)(70)(71)

(72)(73)

(74)(75)(76)

3
(9)

(10)(11)

(12)(13)(14)

(15)(16)

(17)(18)(19)



16. Finally, let's consider entertainment films

In column #1 of the table below, please indicate the number of times you have seen each of the scenes listed below during the last twelve months. If you have not seen it, please enter 0. If you are uncertain, please make your best estimate.

In columns #2, 3 and 4, please circle the number which is your best answer to the following questions.

Column #2 How acceptable do you consider this to be for viewing yourself?

Column #3 How acceptable do you consider this to be for viewing by other adults?

Column #4 How acceptable do you consider this to be for viewing by children?

- Circle the
- 1 if you find it completely acceptable
 - 2 if you find it acceptable in most cases
 - 3 if you find it acceptable in some cases
 - 4 if you find it unacceptable in most cases
 - 5 if you find it completely unacceptable

(20)(21)

(22)(23)

(25)(26)

ENTERTAINMENT FILMS

	Column #1	Column #2	Column #3	Column #4
Scenes in entertainment films showing:	No of times I've seen it in last 12 months	Acceptability for viewing myself	Acceptability for viewing by other adults	Acceptability for viewing by children
<u>Example:</u> Baby eating ice cream with its hands	<u>8</u>	① 2 3 4 5	1 ② 3 4 5	1 2 3 4 ⑤
A. One or more nude women	<u> </u>	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
B. Two adults of the same sex engaged in sex- ual intercourse	<u> </u>	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C. Sex combined with violence	<u> </u>	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
D. One or more nude men	<u> </u>	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
E. A man and a woman engaged in sexual inter- course	<u> </u>	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

(27)(28)

(30)(31)

(32)(33)

(35)(36)

(37)(38)

(40)(41)

(42)(43)



17. For the next section, please read each question carefully and then read through the possible answers. Choose one answer that best reflects your opinion and put the corresponding code in the box.

Example:

What do you believe is the most appropriate thing to do about home movies of a baby eating ice cream with its hands?

- | | | |
|---|---|--------------------------------|
| - Nothing: leave it to personal or family discretion. | 1 | |
| - Censor the movies to remove the offensive parts. . . | 2 | |
| - Forbid access or viewing by children or juveniles. . | 3 | |
| - Require that it be advertised as containing material which may offend some people | 4 | Most appropriate answer |
| - Fine or jail the producer. | 5 | <input type="text" value="1"/> |
| - Ban such material completely | 6 | |
| - Other: _____ | 7 | |
| (please specify) | | |

- a) What do you believe is the most appropriate thing to do about violent sexual scenes shown in magazines?

- | | | |
|---|---|-------------------------|
| - Nothing: leave it to personal or family discretion. | 1 | |
| - Censor the magazine to remove the offensive parts. . | 2 | |
| - Forbid access or viewing by children or juveniles. . | 3 | |
| - Require that it be advertised as containing material which may offend some people | 4 | Most appropriate answer |
| - Fine or jail the producer. | 5 | <input type="text"/> |
| - Ban such material completely | 6 | |
| - Other: _____ | 7 | |
| (please specify) | | |

(45)

- b) What do you believe is the most appropriate thing to do about unrestricted entertainment movies which show nude adults?

- | | | |
|--|---|-------------------------|
| - Nothing: leave it to personal or family discretion. | 1 | |
| - Censor the movies to remove the offensive parts. . . | 2 | |
| - Forbid their being shown to audience including children or juveniles. | 3 | |
| - Require that they be advertised as containing material which may offend some people. | 4 | Most appropriate answer |
| - Fine or jail the producer. | 5 | <input type="text"/> |
| - Ban such material completely | 6 | |
| - Other: _____ | 7 | |
| (please specify) | | |

(46)



c) What do you believe is the most appropriate thing to do about entertainment magazines which show sexual intercourse between two adults of the same sex?

- Nothing: leave it to personal or family discretion. 1
- Censor the magazine to remove the offensive parts. . 2
- Forbid its sale to children or juveniles 3
- Require that it be advertised as containing material which may offend some people 4
- Fine or jail the people responsible for selling it to the public. 5
- Ban such material completely 6
- Other: _____ 7
(please specify)

Most
appropriate
answer

☐

(47)

d) What do you believe is the most appropriate thing to do about late night entertainment programs on TV which show sexual intercourse between a man and a woman?

- Nothing: leave it to personal or family discretion. 1
- Censor the material to remove the offensive parts. . 2
- Require that it be advertised as containing material which may offend some people 3
- Fine or jail the producer. 4
- Ban such material completely 5
- Other: _____ 6
(please specify)

Most
appropriate
answer

☐

(48)

e) What do you believe is the most appropriate thing to do about entertainment movies, in theatres restricted to adults, which show sex associated with violence?

- Nothing: leave it to personal or family discretion. 1
- Censor the show to remove the offensive parts. . . . 2
- Forbid its presentation to audiences including children or juveniles. 3
- Require that it be advertised as containing material which may offend some people 4
- Fine or jail the producer. 5
- Ban such shows completely. 6
- Other: _____ 7
(please specify)

Most
appropriate
answer

☐

(49)



f) What do you believe is the most appropriate thing to do about entertainment magazines, which could be sold at a local store or newstand, which include pictures of nude women?

- Nothing: leave it to personal or family discretion. 1
- Censor the material to remove the offensive parts. . 2
- Forbid its sale to children or juveniles 3
- Require that it be advertised as containing material which may offend some people 4
- Fine or jail the people responsible for selling it to the public. 5
- Ban such material completely 6
- Other: _____ 7
(please specify)

Most
appropriate
answer

☐

(50)

g) What do you believe is the most appropriate thing to do about entertainment magazines, which could be sold at a local store or newstand, which include pictures of nude men?

- Nothing: leave it to personal or family discretion. 1
- Censor the material to remove the offensive parts. . 2
- Forbid its sale to children or juveniles 3
- Require that it be advertised as containing material which may offend some people 4
- Fine or jail the people responsible for selling it to the public. 5
- Ban such material completely 6
- Other: _____ 7
(please specify)

Most
appropriate
answer

☐

(51)

h) What do you believe is the most appropriate thing to do about entertainment programs on TV which shows nude adults at hours when children might be watching?

- Nothing: leave it to personal or family discretion. 1
- Censor the material to remove the offensive parts. . 2
- Forbid its being shown at times when audiences might include children or juveniles. 3
- Require that it be advertised as containing material which may offend some people 4
- Fine or jail the producer. 5
- Ban such material completely 6
- Other: _____ 7
(please specify)

Most
appropriate
answer

☐

(52)



1) What do you believe is the most appropriate thing to do about sexually explicit paintings exhibited in a public art gallery?

- Nothing: leave it to personal or family discretion. 1
- Censor the material to remove the offensive parts. . 2
- Forbid its being shown to audiences including children or juveniles. 3
- Require that it be advertised as containing material which may offend some people 4
- Fine or jail the producer. 5
- Ban such material completely 6
- Other: _____ 7
(please specify)

Most appropriate answer

☐

(53)

18. When you tell us what should be done about unacceptable material, you probably have several criteria or considerations in mind.

In this last question we want to know how important the following criteria are to you when you decide what should be done about material you feel is unacceptable.

Rate the importance to you of each one on the 1 to 10 scale and circle the appropriate answer (1 is not at all important, 10 is very important).

Not at all
important

Very
important

Example:

Whether or not the scenes contain ice cream. 01 02 03 04 05 06 07 08 09 10

- a) Whether or not children are likely to see the unacceptable scenes 01 02 03 04 05 06 07 08 09 10
- b) The level of violence shown. 01 02 03 04 05 06 07 08 09 10
- c) The explicitness of the sexual scenes. 01 02 03 04 05 06 07 08 09 10
- d) Whether or not the primary purpose of material is entertainment rather than art or education 01 02 03 04 05 06 07 08 09 10

(54)(55)

(56)(57)

(58)(59)

(60)(61)

19. What is your exact age? _____

(62)(63)

☐ ☐

THANK YOU ONCE AGAIN FOR YOUR COLLABORATION





APPENDIX B

DESCRIPTION OF THE SAMPLE POPULATION



APPENDIX B

DESCRIPTION OF THE SAMPLE POPULATION

Exhibit B, overleaf, displays the characteristics of the respondents who participated in the omnibus survey and who completed the booklet (percentage figures). The last column of the Exhibit shows the characteristics of the 1981 Statistics Canada census population.*

We see almost identical socio-demographic-economic figures for the omnibus sample and the census population. This is because the sampling technique used in undertaking the omnibus survey ensured proportional representation of each group in the sample to the population. We can also see that the proportion of the omnibus population that also completed the booklet has very similar socio-demographic-economic characteristics to the census population (and hence the omnibus sample population).

* The census figures include Canadians aged 18 years and over in 1981, excluding the Yukon and Northwest Territories. Figures are provided wherever Statistics Canada categories are comparable to the omnibus categories.

EXHIBIT B

SOCIO-DEMOGRAPHIC-ECONOMIC CHARACTERISTICS OF OMNIBUS AND BOOKLET
SAMPLES AND COMPARISON TO 1981 CENSUS POPULATION

	<u>Omnibus</u>	<u>Booklet</u>	<u>1981 Census</u>
Total Sample	2,018	1,641	17,455,650*
<u>Sex Quota</u>			
Sample n	2,018	1,641	
	%	%	%
Males	49	48	49
Females	51	52	51
<u>Age (years)</u>			
Sample n	2,018	1,641	
	%	%	%
18 to 29	30	32	31
30 to 44	28	29	29
45 to 59	21	20	21
60 years and over	21	19	19
<u>Region</u>			
Sample n	2,018	1,641	
	%	%	%
Atlantic	9	9	9
Quebec	27	27	27
Ontario	36	36	36
Manitoba	4	4	8
Saskatchewan	4	4	}
Alberta	9	9	
British Columbia	12	12	11
<u>Community Size</u>			
Sample n	2,018	1,641	
	%	%	%
1,000,000 and over	30	30	30
100,000 - 999,999	28	28	28
5,000 - 99,999	16	16	16
Less than 5,000	26	26	26
<u>Religious Affiliation</u>			
Sample n	2,018	1,641	
	%	%	%
Catholic	45	45	47
Protestant	42	43	41
Other	4	3	
None	9	9	
Refusal	1	1	

(Cont'd)

	<u>Omnibus</u>	<u>Booklet</u>	<u>1981 Census</u>
<u>Employment Status</u>			
Sample n	2,018	1,641	
	%	%	
Working full-time or part-time	58	58	65**
Stay at home full-time	14	14	
Unemployment or looking	10	10	
Student	4	4	
Retired	15	24	
<u>Principal Occupation</u> (of those working full-time, part-time or unemployed and looking)			
Sample n	1,340	1,105	
	%	%	
Professionals, administrators and big business owners	16	16	
Technicians, semi-professionals, administrators and owners of small businesses	13	13	
Office workers, white collar service and sales	38	38	
Tradesman, skilled, semi-skilled and unskilled workers (blue collar) farmers and fishermen			
Others	1	1	
No answer	1	1	
<u>Present Labour Force</u>			
Sample n	1,340	1,105	
	%	%	
Working full-time	67	65	
Working part-time	19	20	
Unemployed or looking	14	15	
<u>Years of Schooling</u>			
Sample n	2,018	1,641	
	%	%	
1 - 8	16	14	
9 - 13	52	53	
14 +	31	32	
<u>Marital Status</u>			
Sample n	2,018	1,641	
	%	%	%
Married or equivalent	68	68	68
Single	21	22	22
Other (widowed, separated or divorced)	11	10	10

(Cont'd)

	<u>Omnibus</u>	<u>Booklet</u>	<u>1981 Census</u>
<u>Income (before taxes) of All Family Members</u>			
Sample n	995	1,622	
	%	%	%
Under \$15,000	23	22	34
\$15,000 - \$24,999	24	25	25
\$25,000 - \$34,999	24	24	20
\$35,000 and over	29	31	21
<u>Language (usually spoken at home)</u>			
Sample n	2,018	1,641	
	%	%	%
French	28	28	25
English	66	67	68
Other	5	4	
<u>Language (of Interview)</u>			
Sample n	2,018	1,641	
		%	
French	25	25	
English	75	75	
<u>Language (Ability to carry out a conversation)</u>			
Sample n	2,018	1,641	
	%	%	
Only in English	63	63	
Only in French	13	13	
Both in English and French	23	24	

* Includes Canadians aged 18 years and over in 1981 excluding the Yukon and Northwest Territories.

** Population of 15 years olds and over.

N.B. Where figures are not given for the 1981 Census this is because the Omnibus categories are not comparable to those used by Statistics Canada.



APPENDIX C

CLASSIFICATION OF QUESTIONS BY ISSUE AREA



APPENDIX C

CLASSIFICATION OF QUESTIONS BY ISSUE AREA

In order to undertake the data analysis and for reporting purposes, the questions in the omnibus and the booklet were classified into questions that deal with prostitution issues and those that deal with pornography issues. Then, the questions were classified according to five major areas: public concepts, use, exposure, legal knowledge and policy options. Our data analysis reported the survey findings according to these five issue areas and the questions covered by each issue area were used as explanatory variables in our regression models.

The type of questions which fall into each of the five areas are described below:

- Public concepts: These questions deal with the definition of prostitution, levels of acceptability toward prostitution and pornography and perceptions and beliefs about prostitution and pornography.
- Use: With respect to prostitution, these questions deal specifically with the frequency of having given or accepted money for sex. In relation to pornography, the questions deal with the frequency of use of adult entertainment by media and type of material being consumed.
- Exposure: These questions deal with the extent of respondents' awareness about prostitution activities and sexually explicit material in their surroundings. Exposure to prostitution was also assessed by questioning whether respondents know someone who has given or accepted money for sex. Questions relating to age of first exposure to actual and pictorial nudity were analyzed in relation to pornography.



- o Legal knowledge: Questions relating to awareness of the law surrounding prostitution and pornography were categorized under legal knowledge.
- o Policy options: Questions dealing with respondents' preferences to deal with prostitution and to control pornography were classified under policy options.

A number of questions did not fit specifically into the prostitution or pornography issue areas. These questions deal with attitudes about personal liberties, sexual equality, etc. and were grouped into a category which was called social sexual attitudes.

One question did not fit into any of the six categories described above. This question investigated whether respondents had been a victim of a sexual offense. Because of its uniqueness, it was treated as a separate category in our analysis.

Question 1A, in the omnibus survey, dealing with the most important social problem facing Canadians, as well, did not fit into any of the categories described above. Because the response pattern showed a concern about pornography (1%), the question was treated as part of the discussion relating to public concepts about pornography.

The question breakdown according to the prostitution and pornography issues and the major categories is shown in Exhibit C, opposite. Question numbers correspond to the numbering in the omnibus and booklet questionnaires (see Appendix A). The question numbering in the omnibus questionnaire begins at 1A, then skips to 49 and ends at 77. In the booklet, the question numbering begins at 1 and ends at 19.

EXHIBIT C

CLASSIFICATION OF QUESTIONS *BY ISSUE AREA

<u>CATEGORY (VARIABLE)</u>	<u>PROSTITUTION</u>	<u>PORNOGRAPHY</u>
Public Concepts	49A, 49B, 50A, 50B, 51A, 52A 71Aa-Ab, 72A, 73A, labdefg, 6a-d, 7a-m	1A, 53Aa-Ae, 57Aa-Ac, 59Aa-Ad, 1bcdfg, 5a-5, 14, 15, 16
Use	67A, 68A	54A, 55Aa-Ad, 56A, 14, 15, 16
Exposure	64A, 65A, 66A, 69A, 70A	58a, 2, 3, 4a-g
Legal Knowledge	74Aa-Af	60Aa-Ac
Policy Options	75A, 76A, 77A, 9a-j, 11a-e, 12a-f,	61A, 62A, 63A, 17a-i, 18
Social Sexual Attitudes		8, 10a-f
Victim of Sexual Offence		13a-b

* Question numbers correspond to numbers in the omnibus and booklet questionnaires.



APPENDIX D

DUMMY VARIABLES USED IN REGRESSION ANALYSES

APPENDIX DDUMMY VARIABLES

Dummy variables are used to analyze the influence of nominal (categorical) variables in regression analyses. In the case of a variable with 2 levels, a variable is created which assigns 1 to one category, and 0 to the other. For a question with n levels, $n-1$ dummy variables are created. Each variable takes on a value of 1 when a particular state is present, and 0 for all other states. One level is arbitrarily assigned values of 0 on all levels (that is why we only need $n-1$ variables).

The significance of the coefficient of the dummy variable indicates the difference between the level which has a value 1 on the particular variable and the level which takes 0 on all levels. Consider the example of religion, where we have 4 categories (Catholic, Protestant, Other Religion, and No Religion). Suppose we created three dummy variables as follows:

$P = 1$ if Protestant, 0 otherwise

$OR = 1$ if other religion, 0 otherwise

$NR = 1$ if no religion, 0 otherwise

Assume we related three dummy variables to a dependent variable Y (e.g., agreement on a certain statement). Consider the following results:

<u>Variable</u>	<u>T-Value</u>	<u>Significance Level</u>
Protestant	3.106	.0000
Other Religion	-1.9604	.0500
No Religion	.0003	.9999



The interpretation here is that:

- Protestants differ significantly from Catholics (the comparison group)
- Other Religions differ significantly from Catholics (in a negative direction)
- there is no significant difference between No Religion and Catholics.

The assignment of dummy variables to the socio-demographic-economic and other explanatory variables used in our regression analysis is described below.

Socio-Demographic-Economic Variables

Dummy variables were created for the nominal-scale socio-demographic-economic variables used in our regression analyses. Exhibit D-1, overleaf, shows the categories of the nominal scale variables we used.

The nominal variable, sex, was treated as one dichotomous variable. Males were assigned a score of 1 and 0 was given to females. Similarly, language was treated as one dichotomous variable, with French respondents assigned a score of 1 and English a 0.

Dummy variables were also created for each of the categories in the nominal variables religion, occupation and geographic area of residence. There are four total religion categories, five occupation groupings and seven geographic regions.

With respect to the employment status variable, one dichotomous variable was created. Respondents who are working full or part-time were considered as employed and assigned a score of 1. Respondents who are unemployed or looking for a job, stay at home full-time, are students or are retired were considered as unemployed and assigned a value of 0.

EXHIBIT D-1

SOCIO-DEMOGRAPHIC-ECONOMIC DUMMY VARIABLES

<u>VARIABLE</u>	<u>NAME OF POTENTIAL DUMMY VARIABLES</u>
<u>Sex</u>	
Males	Sex
Females	
<u>Language (Language of Interview)</u>	
French	Language
English	
<u>Religion</u>	
Catholic	Religion D1*
Protestant	Religion D2
Other	Religion D3
None	Religion D4
<u>Occupation</u>	
Professional, Administrator, by business owner	Occupation D1*
Technical, semi-professional, small business owner	Occupation D2
Clerical, sales and service	Occupation D3
Skilled, semi-skilled and unskilled	Occupation D4
Homemakers	Occupation D5
<u>Geographic Area of Residence</u>	
Atlantic	Atlantic*
Quebec	Quebec
Ontario	Ontario
Manitoba	Manitoba
Saskatchewan	Saskatchewan
Alberta	Alberta
British Columbia	British Columbia
<u>Employment Status</u>	
Working full-time or part-time	Employed
Unemployed or looking, stay at home full-time, student, retired	
<u>Marital Status</u>	
Married or equivalent	Marital
Single, widowed, separated or divorced	
<u>Education</u>	
0 - 8 years	School D1*
9 - 13 years	School D2
14+	School D3

* These were the potential variables. In a given regression, a maximum of n-1 of the variables could be used.



One dummy variable was created for the marital status variable. Married (or equivalent) respondents were assigned a score of 1. All other categories (single, widowed, separated, divorced) were assigned a value of 0 and were considered as single.

Three categories of the education variable were considered--0 to 8, 9 to 13 and more than 14 years of schooling.

Age, income and community size were treated as linear variables and therefore were not assigned dummy variables.

Explanatory Variables

Dummy variables were also created for the explanatory variables used in our regression analyses. All questions, with the exception of 51A, 55Ab, 55Ac, and 60Ab in the omnibus and 1, 5, 6, 10df, 13b, 14, 15, 16 and 17 in the booklet were considered in our regression analysis. Questions dealing with policy options were not considered as explanatory variables. The assignment of each question to an explanatory variable category was described in Appendix C.

The following rules were used in the creation of dummy variables:

- where questions responses were presented as a range (e.g., acceptable in all cases to unacceptable in all cases or agree strongly to disagree strongly), a response at one end of the scale received a value of 1 and subsequent responses received values of 2, 3, etc.
- where questions responses were either yes or no, we treated the question as one dummy variable. Respondents who answered yes were assigned a score of 1 and 0 if they answered no



One dummy variable was created for the marital status variable. Married (or equivalent) respondents were assigned a score of 1. All other categories (single, widowed, separated, divorced) were assigned a value of 0 and were considered as single.

Three categories of the education variable were considered--0 to 8, 9 to 13 and more than 14 years of schooling.

Age, income and community size were treated as linear variables and therefore were not assigned dummy variables.

Explanatory Variables

Dummy variables were also created for the explanatory variables used in our regression analyses. All questions, with the exception of 51A, 55Ab, 55Ac, and 60Ab in the omnibus and 1, ⁵/₆, 10df, 13b, 14, 15, 16 and 17 in the booklet were considered in our regression analysis. Questions dealing with policy options were not considered as explanatory variables. The assignment of each question to an explanatory variable category was described in Appendix C.

The following rules were used in the creation of dummy variables:

- where questions responses were presented as a range (e.g., acceptable in all cases to unacceptable in all cases or agree strongly to disagree strongly), a response at one end of the scale received a value of 1 and subsequent responses received values of 2, 3, etc.
- where questions responses were either yes or no, we treated the question as one dummy variable. Respondents who answered yes were assigned a score of 1 and 0 if they answered no



- where question responses were actual numbers (e.g., frequency of buying adult entertainment magazines), respondents who indicated no or never were assigned a 0 and those who indicated once were assigned a 1. Succeeding numbers were treated as the mid-point of the frequency range (e.g., 3.5 as the mid-point of 2-5 times)
- for open-ended questions, and questions with neither range nor numerical responses, each response category or grouping of similar response categories was assigned a dummy variable. Thus, in the case of each question, the actual dummy variable was assigned a score of 1 and all other dummy variables were assigned a value of 0. Exhibit D-2, overleaf, describes the questions where this rule was applied
- those who answered don't know, refusal, and no answer to a question were not included in the regression analysis.

EXHIBIT D-2

DUMMY VARIABLES FOR EXPLANATORY VARIABLES

<u>Question</u>	<u>Variable</u>	<u>Name of Dummy Variables</u>
52A	What persons are responsible for acts of adult prostitution?	Prostitutes Customers Intermediaries No one Other groups
61A	Who, if anyone; do you believe should take the lead role in controlling sexually explicit material?	Government (all levels) Individuals, family, no one Police and censor boards Other groups (includes church, customs, etc.)
76A	What do you think should be done about prostitution?	Legalization Tougher laws (including tougher laws, arrest, fining, banning) Nothing Social reorientation/education/research
8	At what level, if at all, should sex education be started in schools	Never Primary school Secondary school or higher



APPENDIX E

DESIGN FOR REGRESSION ANALYSES



APPENDIX E

DESIGN FOR REGRESSION ANALYSES

In undertaking our regression analyses, a select number of questions were chosen as dependent variables and models were built in order to understand the influence of the socio-demographic-economic and other explanatory variables (e.g., use, exposure, etc.) on them. This selection process was necessary in order to limit the potentially large number of analyses which could be performed.

Exhibit E-1, overleaf, demonstrates the framework for the regression analyses performed on the prostitution dependent variables. The dependent variables are shown along the top of the Exhibit. The independent variables built into the regression models are shown along the right of the Exhibit. The classification of questions by variable was made according to the manner described in Appendix C. The asterisk indicates which of the independent variables were included into the regression model for each dependent variable.

Exhibit E-2, overleaf, demonstrates the framework for the regression analyses performed on the pornography dependent variables. This Exhibit does not include the framework for the conjoint analysis which looked at the influence of media, scene and audience (independent variables) on levels of acceptability (dependent variable). Responses to questions 14, 15 and 16 in the booklet were used to undertake the conjoint analysis.

EXHIBIT E-1

FRAMEWORK FOR REGRESSION ANALYSES OF PROSTITUTION ISSUES

	DEPENDENT VARIABLES				
	PUBLIC CONCEPTS 49Aa 49Ab 50Aa 50ab	USE 68A	EXPOSURE 64A, 65A, 66A 69A, 70A	LEGAL KNOWLEDGE 74a-f	POLICY OPTIONS 75, 76, 77
INDEPENDENT VARIABLES	Public Concepts 49Aa, 49Ab, 50Aa 50Ab, 52, 71ab, 72A, 73A, 7a-m				
Public Concepts 49Aa, 49Ab, 50Aa 50Ab, 52, 71ab, 72A, 73A, 7a-m	71B, 7g, 71A, 7b, 7j 72A, 73A	*			*
Use 67A, 68A	*				*
Exposure 64A, 65A, 66A, 69A, 70A	*	*			*
Legal Knowledge 74a-f	*	*			*
Socio-Demographic- Economic	*	*	*	*	*
Social Sexual Attitudes 8, 10a, b, c, e	*				*
Victim of a Sexual Offense 13a	*	*			*

EXHIBIT E-2

FRAMEWORK FOR REGRESSION ANALYSES OF PORNOGRAPHY ISSUES

INDEPENDENT VARIABLES	DEPENDENT VARIABLES				
	PUBLIC CONCEPTS	USE	EXPOSURE	LEGAL KNOWLEDGE	POLICY OPTIONS
	59a 59b, 59c 59d 5a, 5i, 5t	54A 55C 56A	55a	60Aa, 60Ac	61A, 62A, 63A
Public Concepts 53a-e, 58A, 59Aa-d, 18a-d		*			*
Use 54A, 55a, 55c, 56A	*				*
Exposure 57a-c, 2, 3, 4a-g	*	*			*
Legal Knowledge 60Aa, 60Ac	*				*
Socio-Demographic- Economic	*	*	*	*	*
Social Sexual Attitudes 8, 10a, b, c, e	*	*			*
Victim of a Sexual Offense 13a	*	*			*



APPENDIX F

SURVEY RESULTS NOT INCORPORATED INTO MAIN REPORT



APPENDIX F

SURVEY RESULTS NOT INCORPORATED INTO MAIN REPORT

This Appendix includes all the survey results of questions which were not elaborated in the main body of the report*. These questions and their responses are shown in Exhibit F-1, overleaf. The questions are organized according to the classification described in Appendix C.

While the results of these questions were not incorporated in the report, most were used as explanatory variables in our regression analyses. (Appendices D and E described the questions which were included in the regression analyses).

The Exhibit shows the response to questions dealing with social sexual attitudes, many of which were found to have a statistically significant relationship with several of the dependent variables of interest. We saw, for example, that the level of schooling in which sex education should be started (question 8) influenced views on many issues. Individuals who indicate that the most appropriate level of schooling to start sex education is secondary school, college/university or never were judged to have relatively conservative social sexual attitudes compared to those who felt it should be started in primary school. The latter group was judged to have relatively liberal or tolerant social sexual attitudes. Our regression analyses also found that the social sexual attitudes elicited in the items in question 10 had a statistically significant relationship with several dependent variables (items a, b, c and e were included in the analyses). With respect to items a, and e, individuals who agree with the statements were judged to have relatively tolerant social sexual attitudes while those who disagreed were judged to have

* Some questions were not incorporated into the main body because they were judged to be similar in nature to other questions dealing with an identical issue. Other questions were, in fact, identical to questions in the main report and thus were used primarily for quality control purposes.

EXHIBIT F-1

SURVEY RESULTS FOR THOSE QUESTIONS
NOT INCORPORATED INTO MAIN REPORT

PUBLIC CONCEPTS (GENERAL)

1. a) Acceptability of exchanging money for sex
- b) Acceptability of seeing a fight between the players at a professional hockey game
- c) Acceptability of buying sexually explicit magazines for private use
- d) Acceptability of men who make a living by playing football
- e) Acceptability of exchanging dinner for sex
- f) Acceptability of women who make their living by posing nude for magazines
- g) Acceptability of the use of pretty girls in advertising for commercial products such as cars or soft drinks

PUBLIC CONCEPTS ABOUT PORNOGRAPHY

5. Indicate the extent to which you agree or disagree with:
 - b) Violent sexual material shown in magazines or movies leads to increased violence against women
 - d) It is better for people to obtain sexually explicit material through mail-orders than from local stores
 - f) Sexually explicit materials become unacceptable only when violence is shown
 - h) Sexually explicit material is degrading to women
 - j) Everyone has the right to view sexually explicit material as long as it is done in private
 - m) Pornography that shows violence as part of a sexual activity is unacceptable to me

PUBLIC CONCEPTS ABOUT PROSTITUTION

7. Indicate the extent to which you agree or disagree with:
 - c) Prostitution in my neighborhood is now more visible than ever before
 - e) In areas where there are no children, prostitution is not a problem

EXPOSURE

1. Could you easily find or see the following in the area where you live:
 - a) Magazines showing nude movies
 - b) Live strip show bars
 - c) Video cassettes featuring sexual acts between adults
 - d) TV movies showing nude adults
 - e) Theatres showing movies with explicit sexual acts
 - f) Material showing violent sexual acts
 - g) Material showing children involved in explicit sexual acts

	<u>ACCEPTABLE(%)</u>	<u>NEITHER(%)</u>	<u>UNACCEPTABLE(%)</u>
	21	10	70
	25	15	60
	41	16	43
	88	6	5
	19	14	65
	36	16	47
	59	14	27
		<u>AGREE(%)</u>	<u>DISAGREE(%)</u>
		70	18
		34	23
		33	50
		57	24
		66	16
		80	11
		<u>AGREE(%)</u>	<u>DISAGREE(%)</u>
		5	60
		13	62
		<u>YES(%)</u>	<u>NO(%)</u>
		75	12
		45	39
		48	20
		56	23
		31	43
		5	50
		20	40

EXHIBIT (Cont'd)

SURVEY RESULTS FOR THOSE QUESTIONS
NOT INCORPORATED INTO MAIN REPORT

SOCIAL SEXUAL ATTITUDES

8. At what level, if at all should sex education be started in schools?

Never	4%
Primary School	59%
Secondary School	28%
College/University	2%

10. Indicate the extent of your agreement or disagreement on the following:

- | | <u>AGREE(%)</u> | <u>DISAGREE(%)</u> |
|--|-----------------|--------------------|
| a) A homosexual would be as acceptable a school teacher as anyone else | 41 | 40 |
| b) A women must have higher sexual morals than a man | 20 | 50 |
| c) The law should enforce sexual morals which agree with my own | 21 | 34 |
| d) Men are better executives than women | 11 | 59 |
| e) A person should be able to do anything as long as it doesn't harm others | 47 | 33 |
| f) A person who runs nude across a public place (a "streaker") is simply amusing | 25 | 33 |

VICTIM OF A SEXUAL OFFENSE

13 a) Have you even been a victim of a sexual offense?

b) At what age did this happen? (If it has happened to you more than once, how old were you the first time?)

Under 4 years old	1%
4-10 years	30%
11-15 years	38%
16-20 years	19%
21-25 years	5%
26-30 years	1%
more than 30 years	0%

<u>YES(%)</u>	<u>NO(%)</u>
10	85



relatively conservative social sexual attitudes. With respect to items b, c, d, individuals who agree with the statements were judged to have relatively conservative attitudes while those who disagreed were considerable as having relatively liberal attitudes.

Exhibit F-2, overleaf shows the results of questions 14, 15 and 16. The results of these questions have already been discussed as part of the conjoint analysis, in the main body of the report. In particular, the level of acceptability held by respondents for a particular scene, media and audience was described with respect to an index of acceptability (see Exhibit 33). Exhibit F-2 provides the same information; however, in terms of the proportion of respondents who find particular situations acceptable or unacceptable.

LEVEL OF ACCEPTABILITY

SCENE	AUDIENCE	MEDIA	ACCEPTABLE(%)*	UNACCEPTABLE(%)**
Nude Woman	Myself	T.V.	59	24
		Magazines	56	25
		Films	55	23
	Other Adults	T.V.	60	20
		Magazines	56	23
		Films	56	20
	Children	T.V.	18	63
		Magazines	15	64
		Films	14	62
Homosexual Intercourse	Myself	T.V.	25	54
		Magazines	27	53
		Films	25	51
	Other Adults	T.V.	32	48
		Magazines	31	45
		Films	34	45
	Children	T.V.	3	75
		Magazines	3	74
		Films	3	72
Sex With Violence	Myself	T.V.	13	67
		Magazines	12	65
		Films	11	64
	Other Adults	T.V.	17	61
		Magazines	16	60
		Films	16	58
	Children	T.V.	2	76
		Magazines	4	73
		Films	1	74
One or More Nude Men	Myself	T.V.	47	33
		Magazines	45	34
		Films	46	31
	Other Adults	T.V.	52	28
		Magazines	49	28
		Films	50	26
	Children	T.V.	16	65
		Magazines	14	64
		Films	13	63
Heterosexual Intercourse	Myself	T.V.	46	36
		Magazines	42	36
		Films	46	32
	Other Adults	T.V.	48	32
		Magazines	44	32
		Films	47	28
	Children	T.V.	9	70
		Magazines	9	69
		Films	8	68

* Completely acceptable, acceptable in most cases and acceptable in some cases.

** Unacceptable in most cases, completely unacceptable.



APPENDIX G

AREAS OF FUTURE RESEARCH



APPENDIX G

AREAS OF FUTURE RESEARCH

This appendix elaborates a number of areas of future research which can be performed with the data base collected from this national population survey. The information which has been accumulated is very substantial and the possibilities for further analyses are just as great. As such, our intent is to highlight some potential areas of analysis, rather than provide an exhaustive list. Specifically:

- o Further statistical modelling can be performed in order to understand the influence of the socio-demographic-economic and other explanatory variables on the dependent variables of interest. As described in Appendix E, only a selected number of questions were examined in our regression analyses. Thus, further work can be undertaken by examining questions which have not already been so analyzed.
- o Views held toward pornography and prostitution were examined in Chapter IV of the report. In comparing attitudes towards the two issues, it would be possible to assess differences in the socio-demographic-economic characteristics of individuals who feel the same way about both issues and those that feel distinctly different about each issue (i.e., shift their views on the respective issue). This type of analysis could also involve modelling.
- o Further analysis can be undertaken in order to understand the reasons for individuals' preferences for specific policy options responses to questions dealing with public concepts and those dealing with policy option preferences can be compared in order to determine, for example:



- whether individuals who believe prostitution is a major cause in the spread of venereal disease are those who desire a requirement for prostitutes to have medical examinations
- whether individuals who believe prostitution has an effect on residential property values also favour zoning restrictions for prostitution
- whether those who are offended by solicitation also desire tougher laws against the prostitute
- whether individuals who believe pornography has harmful effects on children also propose restrictions on the availability of such material to children.

As well, responses relating to policy option preferences to deal with the two issues can be compared with specific preferences for control actions in order to determine whether there is consistency in response, for example:

- whether respondents who favour a legalization approach for prostitution also favour zoning of designated areas, licensing of prostitution, etc.
 - whether respondents who favour tougher laws to deal with prostitution also favour various actions involving more control, prosecution of prostitutes, pimps, etc.
 - whether respondents who favour government control over sexually explicit material also favour strict actions over specific types of material
- o Our analyses showed that a number of socio-demographic-economic variables have a statistically significant relationship with the dependent variables (e.g., sex, religion, language, age, geographic area of residence,



etc.). An in-depth analysis of any of these variables could be performed to better understand different response patterns. Further insight could be obtained by supplementing this analysis with other social science research performed on these socio-demographic-economic variables.

- o Further work could also be undertaken in order to understand the characteristics of consumers of pornography. Individuals that consume magazines, videos and films can be grouped together (6% of the sample) and an analysis of the socio-demographic-economic characteristics of these individuals could be examined.

These suggestions are meant to be indicative of, rather than a comprehensive listing of, the types of analyses which could (and should) be carried out.

CAI
J 800

-83P107

WORKING PAPERS ON PORNOGRAPHY AND PROSTITUTION

Report # 7

THE LADIES (AND GENTLEMEN) OF THE NIGHT AND THE SPREAD OF SEXUALLY TRANSMITTED DISEASES

by
M. Haug
and
M. Cini

POLICY, PROGRAMS
AND RESEARCH BRANCH

RESEARCH AND
STATISTICS SECTION

THE LADIES (AND GENTLEMEN)
OF THE NIGHT
AND THE
SPREAD OF SEXUALLY TRANSMITTED
DISEASES

Margot Haug
Maltaise Cini

May, 1984

The views expressed in this
report are those of the
authors and are not
necessarily shared by the
Department of Justice.

Acknowledgements

We would like to thank all of the people who helped us in the preparation of this document especially Dr. Jessamine, Marion Todd, and Dr. Hockin, of the Laboratory Centre for Disease Control, Health and Welfare Canada for their expert advice, Sue Higgins for her invaluable help in finding publications, Daniel Sansfaçon for his infinite patience and for his perceptive comments, Bernard Starkman, Patricia Bégin, Yvon Dandurand, for their expert advice and John Clappe for his expertise in the field.



Executive Summary

The purpose of this paper is to determine whether prostitutes make a significant contribution to the spread of sexually transmitted diseases (STD's) and to determine which measures are most effective in controlling the problem.

The study concludes that female prostitutes do not make a significant contribution to the spread of STD's since although female streetwalkers* have a higher incidence of gonorrhea than do women to whom they were compared, four in every five cases of gonorrhea in the U.K. (Turner and Morton 1976) could be traced to a woman who was not a prostitute. In 1983, Dr. Neumann (1983:155) concluded that this figure has decreased and that prostitutes now contribute to less than one in every ten cases.

The reason for this finding is based upon common sense. Since prostitutes now form a very small percentage of the sexually active population, since they frequently engage in oral sex which infrequently results in the infection of a client**, and since most prostitutes regularly use prophylactics, they are not important transmitters of STD's even though they may be more frequently infected than the average person.

Common sense also leads us to the conclusion that it is perhaps the young male aged 20 to 24 which makes a significant contribution to the spread of STD's. In the U.K., Canada and the U.S., gonorrhea is diagnosed more frequently in this group than in other age groups composed of males and females. As well, this group forms a significant proportion of the sexually active population and is not particularly well informed about the prevention and treatment of STD's.

In focusing upon the prostitute we try to find an easy solution to a complex problem. Not surprisingly research studies and common sense show that this approach is not only ineffective in controlling the spread of STD's but also raises serious moral and human rights questions. The most effective control measures are based on public education and specialized, easy to access, health care facilities.

Therefore, the issue is not whether prostitutes significantly contribute to STD's but rather what should or can be done about a growing social problem. We conclude that, in Canada, this problem could be addressed in the following ways:

- Conduct multidisciplinary research, which does not discriminate against women, to determine which medical and social measures are effective in reducing the prevalence of STD's;
- Pay serious attention to the problem of incest and its relationship to STD's in Canadian children;
- Educate the Canadian public, STD patients, the medical and social welfare profession, high risk groups and politicians about STD'S and their prevention.

* Most studies ignore male prostitutes.

** Dr. Jessamine, personal interview.

TABLE OF CONTENTS

Executive summary	
	Page
Introduction.....	1
Methodology.....	2
I. The Incidence of STD's in Canada.....	2
• gonorrhea	
• syphilis	
• herpes	
• chlamydial infections	
• AIDS and PPNG	
• Conclusion	
II. The Reported Incidence of STD's in other Western Countries.....	7
• Conclusion	
III. Prostitution and STD's: Research in the U.S.A. and the U.K.....	8
• Conclusions.....	14
IV. The Control of STD's in prostitutes.....	15
• Conclusions.....	19
Definitions and Notes	
Bibliography	
Appendice I : National and international venereal disease legislation	
Appendice II : A Survey of STD Clinics in Canada	

Introduction

The purpose of this paper is to examine whether prostitution makes a significant contribution to the spread of sexually transmitted diseases (STD's), and to determine which measures to control the spread of these diseases, by prostitutes, have been effective in the past (1).

STD's can engender a great deal of harm (2). They can pose a serious health problem for prostitutes as well as for the clients of prostitutes. Complications such as pelvic inflammatory disease, ectopic pregnancies, and involuntary infertility, impose a large human and financial cost upon society. Pelvic inflammatory disease alone, costs the Canadian economy about \$28 million dollars every year; \$400,000 for office visits, \$22.6 million for operative procedures and \$5 million for loss of time from work, (Romanowski 1983:153). Uncomplicated STD's and their consequences, in the late 1970's, cost the Canadian economy over \$200,000,000 annually, (Jessamine et al. 1983:164). This figure does not, however, even begin to measure the social and personal cost of STD's.

This paper focuses upon the relationship between sexually transmitted diseases and prostitution since some people have stated that prostitutes make a significant contribution to the spread of STD's while others say that promiscuity is more of a problem than prostitution. Although this paper can not determine once and for all how large a contribution prostitutes make to the spread of venereal disease in Canada, (since the data to prove such a statement do not exist), it can attempt to answer this question for other Western nations where such studies have been conducted.

If one can prove that prostitutes do make a significant contribution, then it can be argued that special measures are needed to control this problem. In order to answer questions policy makers have about control measures, this paper describes and evaluates the effectiveness of methods used to limit the spread of STD's by prostitutes.

1. See the section titled 'Definitions and Notes for an outline of the various infections that are traditionally classified under the title 'sexually transmitted diseases'.

2. Self-inflicted venereal disease is a recognized phenomenon. English prostitutes who offered their 'services' to members of the British Expeditionary Force to France during the First World War, charged higher prices when they knew they were diseased because a case of V.D. meant removal from the trenches. (Adler 1980:208)

Methodology

In order to study these questions we reviewed the literature on prostitution and sexually transmitted diseases. To our knowledge no empirical work has been done in Canada on the possible link between prostitution and the spread of STD's. Most studies are either American or British. However, in Canada as in most Western countries, data are collected on the incidence of some STD's and their complications.

I. THE INCIDENCE OF STD's IN CANADA

The Department of Health and Welfare Canada publishes yearly data on the national incidence of sexually transmitted diseases, (i.e. the number of new cases every year)(3). This data is collected by the provinces and sent to Statistics Canada. The Department's 1982 report, Sexually Transmitted Diseases in Canada 1982, included data on gonorrhea, syphilis, infectious syphilis, latent syphilis, acquired immune deficiency syndrome (AIDS), herpes virus infections, and chlamydial infections. However, the magnitude of the STD problem in Canada is underestimated due to two factors: non-compliance with the reporting system; and the small number of reportable STDs, (only the 'traditional' venereal diseases are reportable.)

Canada's national reporting system does not include certain sexually transmitted infections such as non-gonococcal genital infection, trichomoniasis, and genital warts, which, according to this report, are estimated to occur at least as frequently as gonorrhea.

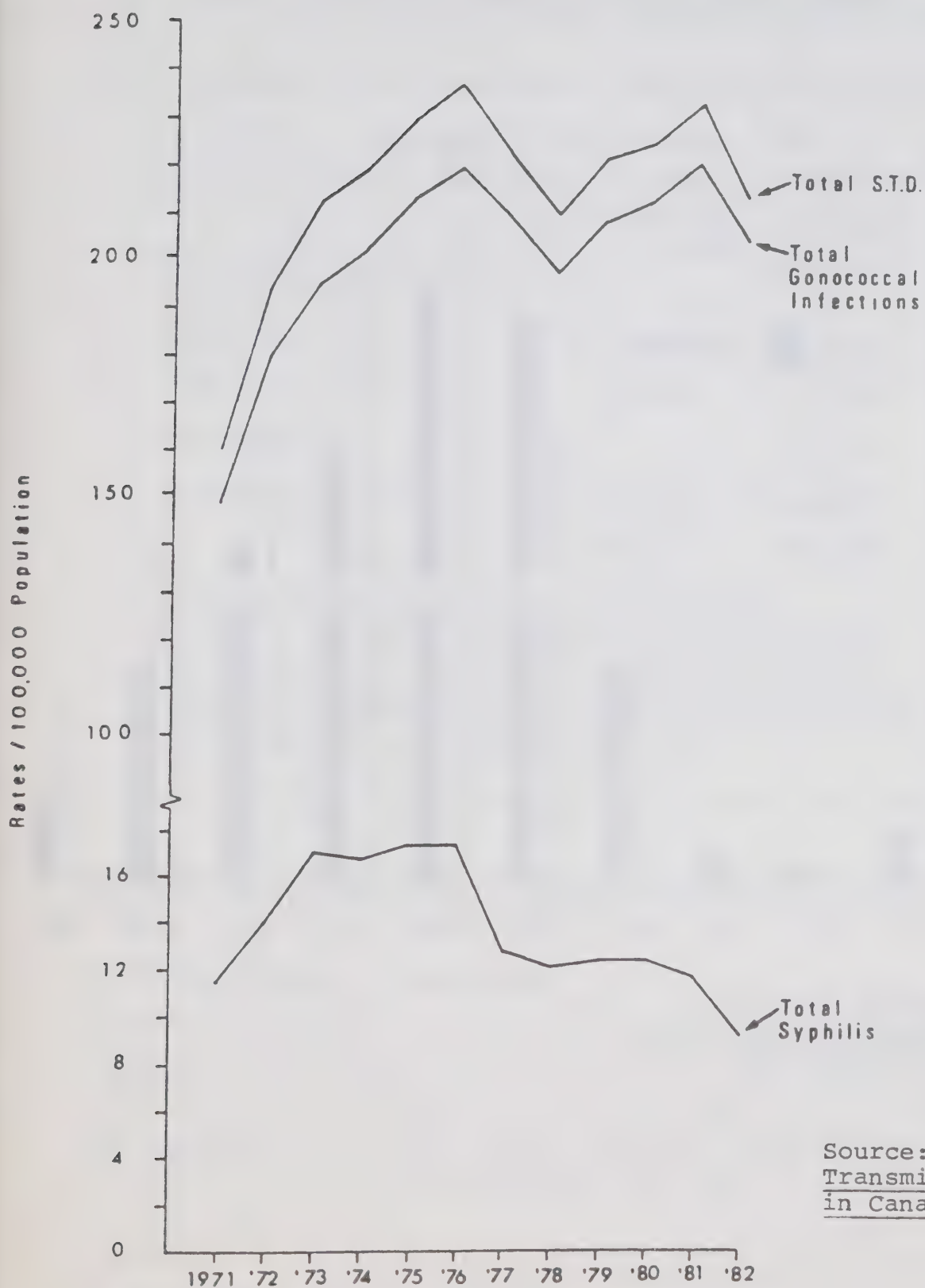
"It is estimated that there are 3 cases of non-gonococcal urethritis and cervicitis for every case of gonorrhea seen, 1 case of herpes for every 5 cases of gonorrhea, and venereal warts are diagnosed as frequently as gonorrhea by private practitioners and VD clinics."
(Department of Health and Welfare Canada 1983:1)

It is believed that about one third of all cases of gonorrhea are reported to provincial governments, and about 90% of all cases of syphilis are reported (4). The publically funded STD clinic is most likely to report a case whereas student health services, hospitals, and private M.D's

3. Note the difference between this term and 'prevalence'. See the section titled 'Definitions and Notes.' All of the statistics and information on STD's in Canada outlined in the following section comes from Health and Welfare Canada's report titled Sexually Transmitted Diseases in Canada 1982.

4. Personal interview with Dr. Jessamine, Marion Todd, and Dr. Hockin of the Laboratory Centre for Disease Control, Health and Welfare Canada.

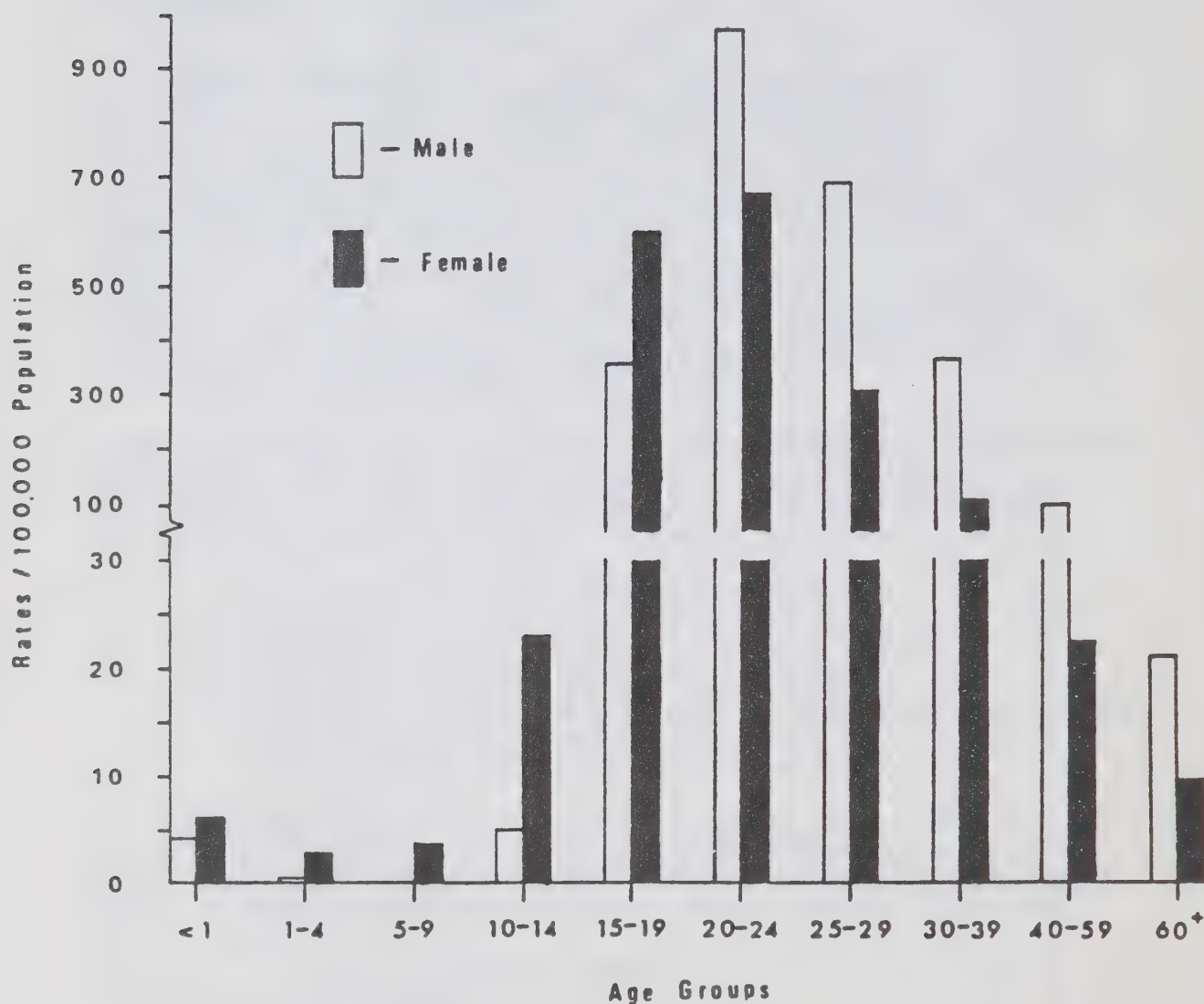
Figure 1
 TOTAL NOTIFIABLE SEXUALLY
 TRANSMITTED DISEASE (STD), CANADA, 1971-1982
 - Rates/100,000 Population By Year



Source: Sexually
 Transmitted Diseases
 in Canada 1982

Figure 2

TOTAL NOTIFIABLE SEXUALLY
TRANSMITTED DISEASE (STD), CANADA, 1982
- Rates/100,000 Population By Age Groups and Sex



Source: Sexually
Transmitted Diseases
in Canada 1982

are less likely to do so (5). (Private M.D.'s usually do the least reporting.) As a result of these two factors - non-reporting and the small number of reportable diseases - the real incidence of sexually transmitted diseases in Canada is much higher than our national statistics indicate.

The following table calculates the real incidence of these diseases.

TABLE I: Incidence of STD's in Canada, 1982

	Reported*	Estimated**
Non-gonococcal urethritis and cervicitis	-	477,900
Gonorrhea	53,100	159,300
Syphillis	1,000	1,100
Genital warts	-	159,300
Herpes(genital isolates)	2,600	31,900
Total	56,700	829,500

(All figures rounded off to the nearest hundred.)

* Source: Sexually Transmitted Diseases in Canada 1982

** Derived from the estimated real incidence of each of these diseases outlined on page 1 of Sexually Transmitted Diseases in Canada 1982 and from information provided by Dr. Jessamine, Dr. Hockin and Marion Todd, Laboratory Centre for Disease Control, Health and Welfare Canada.

Since each STD has different characteristics and a unique incidence rate each one will be analyzed separately in the following section.

Gonorrhea in Canada

Gonorrhea is a very old disease - it was known to the early Chinese in the time of Emperor Huang-ti, 2637 B.C. Gonorrhea in males is usually symptomatic and it takes less than a week, after having contacted the infection, before the symptoms become evident. Females, on the other hand, often do not know they are suffering from this infection. Since the symptoms are often trivial, about 20 percent suspect they have the disease and 80 percent have no symptoms at all (6).

5. Ibid.

6. Dr. Jessamine, personal interview.

Figure 3 shows that the incidence of gonorrhea in Canada rose during the Second World War and sharply declined in the 1950s. By the early 1970's it was on the rise again. Gonorrhea has the highest reported incidence of all notifiable STD's in Canada with 95.9% of the total cases followed by syphilis (4%) with all others accounting for 0.1%.

Reported cases are highest in young males between the ages of 20 and 24 (946.4 cases per 100,000 persons in 1982) followed by women in this same age group (663.3) and males between the ages of 25 and 29 (657.0).(7).

A startling finding is the number of reported cases of gonorrhea in children. (See Table II) Three hundred and thirty-one cases were reported in 1982 in children under the age of 14. Eighty-three percent of these cases were recorded in females. Health and Welfare Canada believes that this figure would be even higher if it weren't for non-reporting. (Health and Welfare Canada 1984:51) If we adopt the rule of thumb used above to estimate the 'real' incidence of gonorrhea, we estimate that there were almost 1,000 cases in 1982. Although some cases involve newborns who catch the disease during delivery, Health and Welfare Canada (1983,1984) state that gonorrhea in children should be treated as an indicator of sexual abuse.

"... most childhood gonorrhea is thought to be transmitted through sexual abuse. Very little information is available on the frequency of sexual abuse of children in Canada, but any venereal disease diagnosed in a child between 1 year of age and puberty should be considered an indicator of this problem until proven otherwise." (Health and Welfare Canada 1984:50)

Suzanne Sgroi (1982) would agree with this position. She states that except for neonatal infection and gonococcal eye infection, little evidence exists to support a theory of nonsexual transmission of gonorrhea to persons of any age group.

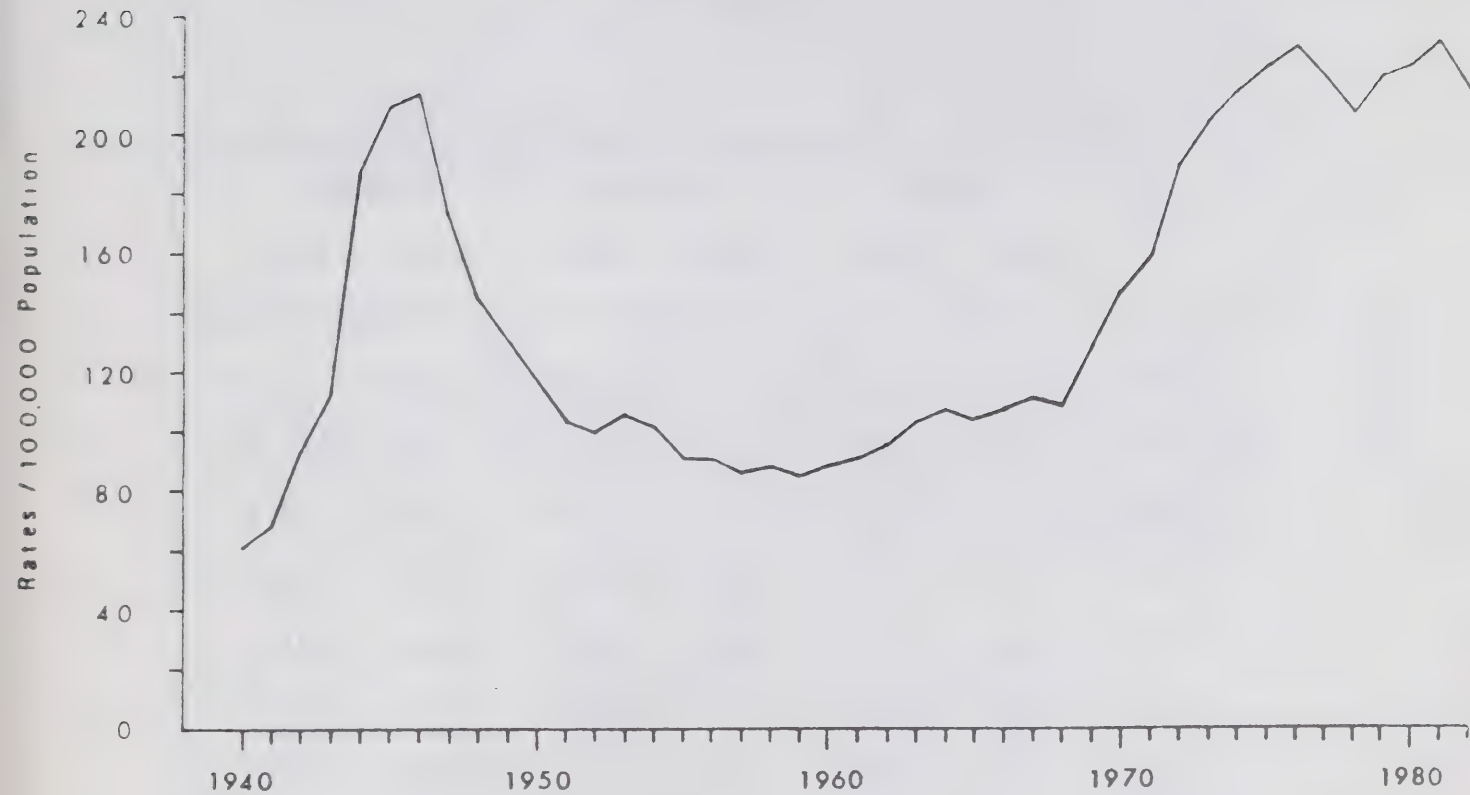
Syphilis in Canada

The name 'syphilis' has its origins in a poem written by Frascatorius in 1530. The poem describes a swineherd, named Syphilis, who acquired the infection. This infection is of great chronicity and can attack all parts of the body. The Registrar General recorded 1639 deaths in adults and 1200 in infants from this illness in 1910 in England and Wales. These figures were thought to be grossly underestimated since

7. Males in the 20-24 year old age group have had a much higher rate of gonorrhea (about 30% higher) than any other group over the last five years. It has ranged from 871 to 1021 cases per 100,000 persons.

Figure 3

TOTAL GONORRHEA, CANADA, 1940-1982
- Rates/100,000 Population By Year



Source: Sexually Transmitted Diseases in Canada 1982

Source: Sexually Transmitted
Diseases in Canada 1982 -

TABLE II

TOTAL GONORRHEA BY AGE AND SEX

CANADA, 1982

AGE	MALES		FEMALES		TOTAL ¹	
	CASES	RATE	CASES	RATE	CASES	RATE
< 1	7	3.7	9	5.0	16	4.4
1-4	3	0.4	22	3.1	25	1.7
5-9	1	0.1	32	3.7	33	1.9
10-14	46	4.7	211	22.9	257	13.6
15-19	4 063	353.8	6 563	598.8	10 626	473.4
20-24	11 239	946.4	7 816	663.3	19 058	805.5
25-29	7 310	657.0	3 363	299.5	10 675	477.5
30-39	6 399	335.9	1 899	0.4	8 298	218.6
40-59	2 169	85.8	422	16.6	2 591	51.1
60+	147	9.7	21	1.1	168	4.9
TOTAL *	32 081	262.8	20 894	168.1	53 076	215.4

NOTE: Rates are given per 100 000

1. Totals include cases not specified for sex.

* Includes cases not specified for age or sex.

many deaths were not certified as having been caused by syphilis. Sir William Osler, regius professor of medicine at Oxford, calculated in 1917 that adult deaths alone due to syphilis probably numbered 60,000 instead of the reported figure of less than 2,000. (Adler 1980:206) Today with the help of modern medicine, over 50 per cent of those infected will not suffer serious physical consequences as a result of this illness.

In Canada, reported cases of syphilis rose sharply during the war years, declined in the late 1940s and has not risen since then. (See Figure 4) As is the case with gonorrhea, syphilis is generally a young person's disease - especially a young male's disease; 62% of all cases of infectious syphilis were reported in males 25-39 years of age in 1982. The incidence of this infection is much higher in males than females apparently due to homosexually acquired syphilis. (Health and Welfare Canada 1983:18)

Herpes in Canada

Herpes, or 'herpes simplex virus infection' (HSV) as it is known by the medical profession, produces not only cold sores but also a genital infection. The epidemiology* of the disease has been clarified by the detection of two antigenic* variants, HSV-1 and HSV-2. In most cases, HSV-1 causes lesions above the waist and HSV-2 causes herpes lesions below the waist. Unlike gonorrhea, herpes cannot be cured although its effects can be reduced through the use of medication and psychological support. (See Figure 5)

Although herpes is not a reportable disease twenty-two Canadian laboratories collaborating with the World Health Organization submitted 6,224 reports of herpes virus infection to the Laboratory Centre for Disease Control in Ottawa in 1982. Where the antigenic variant of the herpes case was reported, HSV-2 (lesions below the waist) were reported in 219 males (3.5% of reported cases) and 262 females (4.2%). The 20-24 year old age group was most frequently infected (22.3%) by both variants of herpes followed by the 30-39 (17.3%) and 25-29 year old age group (16.4%).

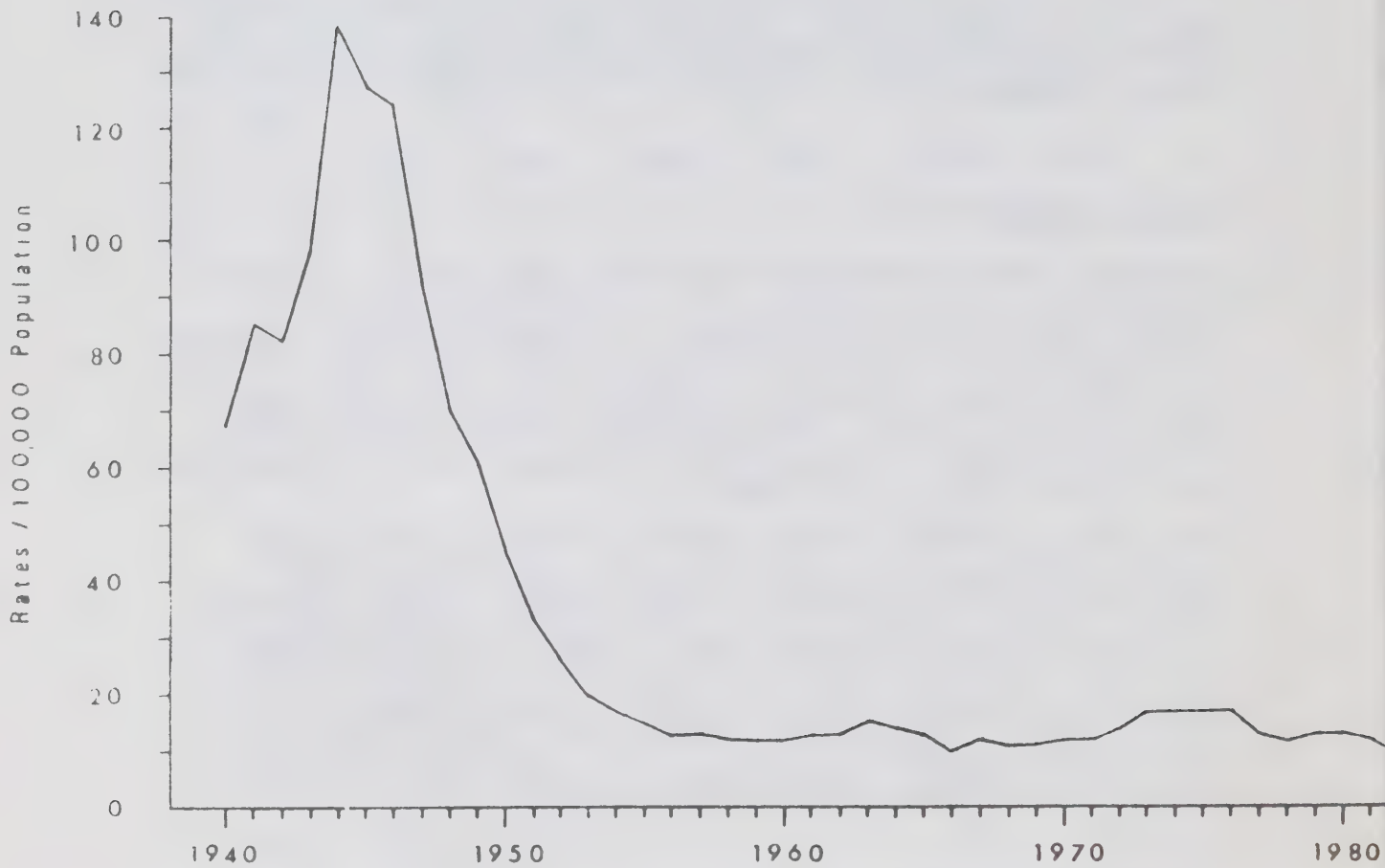
Chlamydial Infections

These infections are reported to the Bureau of Microbiology, Department of Health and Welfare Canada by twenty-two labs collaborating with the World Health Organisation. In 1982 there were

* See the section titled 'Definitions and Notes' for an explanation of this term.

Figure 4

TOTAL SYPHILIS, CANADA, 1940-1982
- Rates/100,000 Population By Year



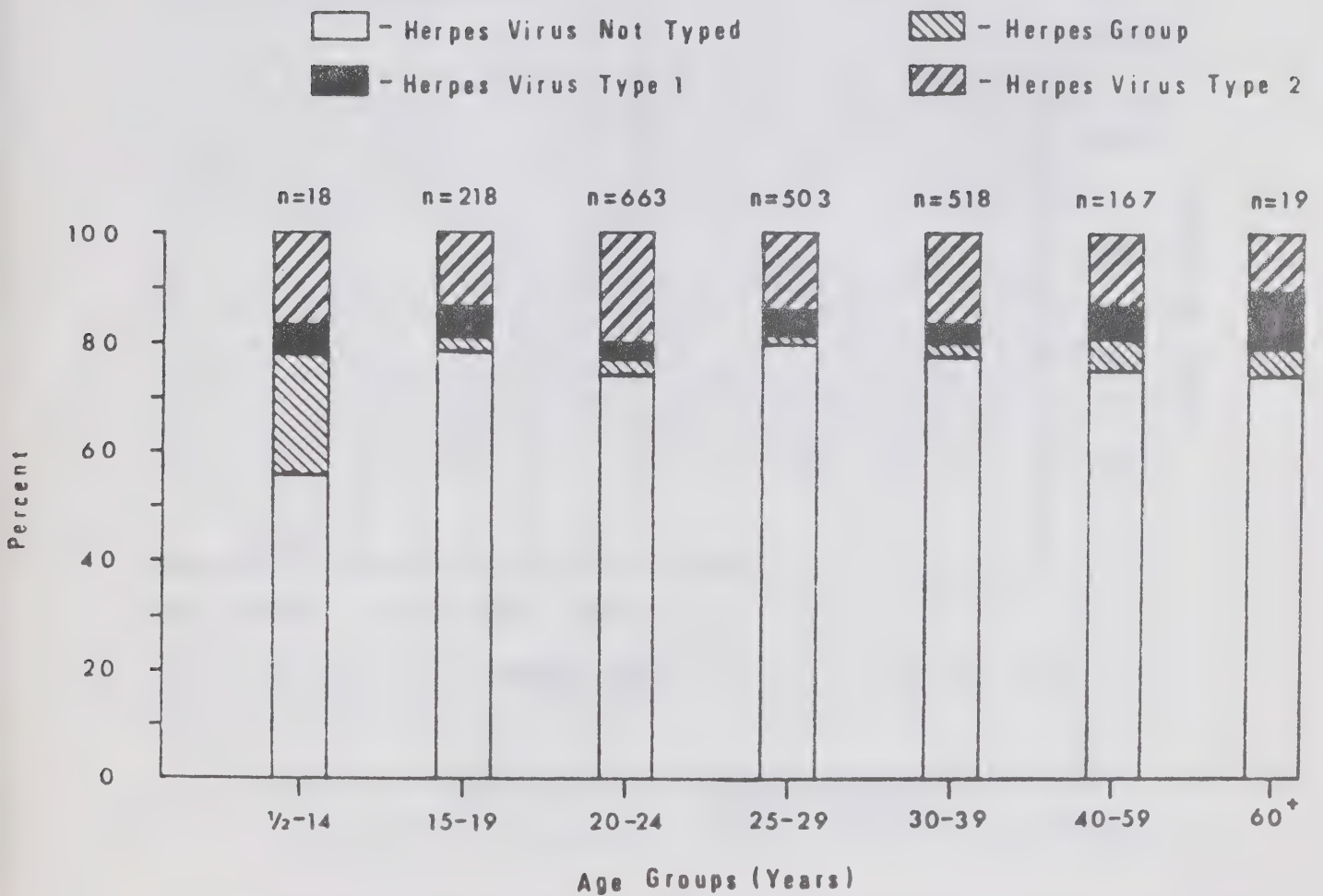
Source: Sexually Transmitted Diseases
in Canada 1982

Figure 5

HERPES REPORTS OF GENITAL TRACT SPECIMENS

- Percent By Age Groups and Virus Type

- Canadian Virus Laboratories, 1982

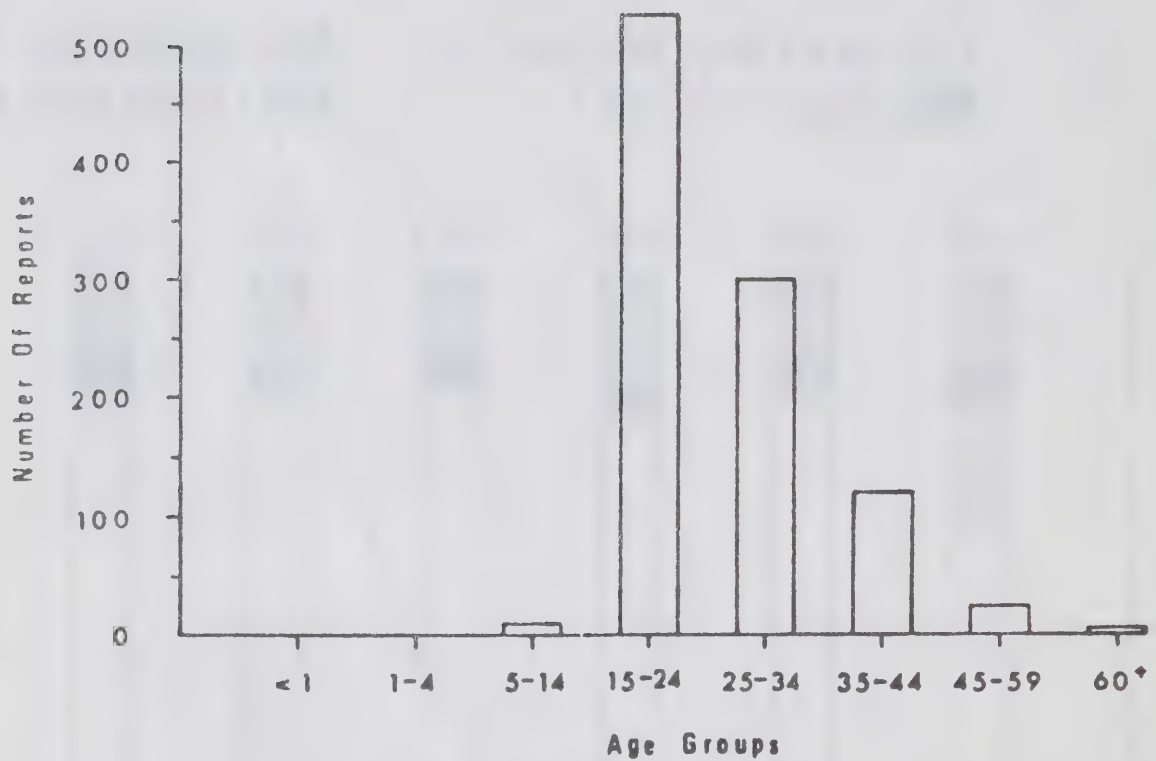


Source: Sexually Transmitted Diseases in Canada 1982

Figure 6

CHLAMYDIA REPORTS OF GENITAL TRACT SPECIMENS

- Number of Reports By Selected Age Groups
- Canadian Virus Laboratories, 1982



Source: Sexually Transmitted Diseases
in Canada 1982

1,724 reports of chlamydial infections in Canada. According to the Department's report the real yearly frequency of chlamydial infections, such as non-gonococcal urethritis and cervicitis, is about three times higher than gonorrhea, (Health and Welfare Canada 1983:1).

Of the 1,724 cases reported, 68% involved females and 29% males. The 15-34 age groups accounted for 82.9% of all reports. Of the reports where the type of lesion was specified, 75% were from the genital track. (See Figure 6)

Acquired Immune Deficiency Syndrome (AIDS) and Penicillinase-Producing Neisseria Gonorrhoeae (PPNG)

Although only a small number of cases of both of these infections are reported annually the number of cases of penicillinase-producing neisseria gonorrhoeae (PPNG) is increasing in Canada. Since 1976 there have been 175 isolations reported by the Antimicrobials and Molecular Biology Unit, Laboratory Centre for Disease Control, Health and Welfare Canada, 41.7% of which occurred in 1982. Most PPNG were acquired in other countries, notably Asia.

As of April 1984, 74 cases of AIDS have been reported to the Laboratory Centre for Disease Control. Thirty-nine patients have died which totals a 52% case fatality rate. Thirty-seven patients were Canadian born, twenty were from Haiti and six were from other countries. A homosexual/bisexual orientation was recorded in 41 cases, heterosexual in 27 cases and in 2 cases the preference was unobtainable or not applicable. (One case was a four month old child of Haitian origin.)

Conclusion

Despite underreporting we can make a number of conclusions about STD's in Canada since the data reveal similar patterns from year to year. These conclusions are as follows:

- age and sex are significant factors in the transmission of STD's. Gonorrhea is most frequently diagnosed in young males aged 20-24. Most STD's are caught by males and females aged 15-30, and
- STD's in children, especially female children under the age of 14, is not uncommon.

II. The Reported Incidence of STD's in other Western Countries

The reported incidence of STD's in Canada over the last five years reveals that males aged 20-24 are a high risk group. One might conclude that this group is responsible for a larger share of most STD's than other sex and age groups. However, since STD's in Canada are underreported, and since those agencies that do report are usually frequented more by males than by females, (8) we must examine the data from other Western countries. If the same patterns emerge, perhaps young males have a higher incidence of certain STD's and, therefore, make a larger contribution to the transmission of STD's than any other sex or age group.

The following table for the U.K. (Table IV) indicates that from 1976-1980 the highest rates for reported STD's were for gonorrhea in males 20-24 years of age. These rates varied from 728 cases per 100,000 population to 659. The highest female gonorrhea rates were in the 16-19 and 20-24 year old age groups. These rates hovered around 500 cases per 100,000 for the five year period.

Age and sex specific rates for gonorrhea in the U.S. show a similar pattern. From 1976 to 1979 the highest rates of gonorrhea were again found in males (whether white or nonwhite) in the 20-24 year age group. As well, these rates are significantly higher than rates for females in the same age group.

Conclusion

These data lead us to the conclusion that the incidence of gonorrhea appears to be highest in the young male aged 20-24 in Canada, the U.K. and the U.S. Since this group makes up a large percentage of the sexually active population we could conclude that it makes a larger contribution to the spread of gonorrhea than any age group, whether it be male or female. However, these official statistics tell us nothing about the contribution different 'occupational' categories (such as prostitutes) make to this problem. For this reason, we now turn to studies that have attempted to answer this specific question.

8. Dr. Jessamine, personal interview.

TABLE III

U.S.

Age-specific and Age-adjusted Gonorrhea Rates (per 100,000) for White Men and Women in the United States (excluding New York and California) 1967-1979

Sex, Age (Years)	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979
Men													
≤ 14	1	1	1	2	2	2	3	3	3	3	3	3	4
15-19	156	170	203	251	316	365	369	377	393	370	341	336	340
20-24	553	638	703	780	901	1,004	1,007	1,028	1,060	1,007	955	922	909
25-29	329	350	381	399	470	507	549	580	642	622	638	629	626
30-39	118	128	133	145	163	174	183	198	229	238	251	250	255
40-49	37	38	39	44	45	46	47	50	59	62	68	69	75
≥ 50	13	13	13	14	14	15	14	17	18	19	20	20	21
Total													
Unadjusted	94	106	121	141	173	197	206	220	240	239	238	237	240
Age-adjusted	107	118	129	143	165	182	187	195	210	205	203	199	201
Women													
≤ 14	3	4	4	5	8	10	12	12	14	13	13	14	14
15-19	121	144	185	234	354	487	587	650	705	661	645	643	644
20-24	178	202	237	295	383	542	686	757	802	744	723	692	692
25-29	82	87	101	111	150	193	253	285	318	293	302	290	293
30-39	27	31	31	36	46	62	76	79	88	88	86	82	83
40-49	8	9	10	10	12	15	17	18	19	18	19	19	19
≥ 50	3	3	3	3	4	4	5	6	6	6	5	5	5
Total													
Unadjusted	38	44	54	67	95	131	164	184	201	191	189	185	186
Age-adjusted	36	41	48	58	80	109	136	149	161	151	149	145	145

Age-specific and Age-adjusted Gonorrhea Rates (per 100,000) for Nonwhite Men and Women in the United States (Excluding New York and California), 1967-1979

Sex, Age (Years)	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979
Men													
≤ 14	33	42	44	51	50	56	56	57	57	56	55	53	53
15-19	4,223	4,551	5,121	5,295	5,322	5,559	5,724	5,772	5,687	5,326	4,958	4,711	4,446
20-24	11,578	12,984	13,967	14,007	13,600	13,693	12,780	13,173	13,991	13,225	12,678	11,853	10,809
25-29	7,430	7,570	7,877	7,760	7,825	8,012	8,184	8,651	9,073	8,487	8,487	8,154	7,543
30-39	2,750	2,866	2,950	2,989	2,947	2,992	2,960	3,092	3,266	3,172	3,193	3,077	2,942
40-49	810	817	834	835	813	816	804	836	894	888	870	886	832
≥ 50	186	181	204	202	205	201	219	231	266	256	292	275	250
Total													
Unadjusted	2,059	2,237	2,495	2,654	2,733	2,876	2,872	3,025	3,228	3,144	3,112	3,002	2,819
Age-adjusted	2,385	2,549	2,714	2,728	2,695	2,742	2,695	2,794	2,926	2,776	2,715	2,587	2,404
Women													
≤ 14	50	56	66	80	82	100	130	144	163	158	147	158	165
15-19	1,852	2,090	2,414	2,608	2,948	3,854	5,161	5,683	5,980	6,084	6,024	6,268	6,099
20-24	2,586	2,767	3,163	3,252	3,465	4,365	5,792	6,341	6,648	6,694	6,594	6,643	6,264
25-29	1,351	1,318	1,526	1,532	1,597	2,040	2,589	2,698	2,954	2,799	2,808	2,874	2,756
30-39	446	455	479	501	501	632	809	836	882	801	785	798	765
40-49	113	112	100	106	113	133	161	190	187	185	158	159	154
≥ 50	35	25	40	33	34	46	49	63	75	55	50	52	47
Total													
Unadjusted	573	628	739	802	889	1,159	1,555	1,723	1,852	1,873	1,864	1,922	1,847
Age-adjusted	551	581	660	688	737	941	1,232	1,338	1,418	1,399	1,377	1,409	1,353

Source: Sexually Transmitted Diseases, vol. 10
no. 2, p.73-74.

TABLE IV

U.K.

Venereal diseases—new cases per 100 000 population by age seen at hospital clinics in England 1976-80

	1976			1977			1978			1979			1980		
	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total
Early syphilis															
All ages	8.86	1.50	5.08	9.67	1.71	5.59	10.27	1.91	5.98	10.77	1.77	6.16	9.54	1.59	5.46
Primary and secondary only	6.40	0.87	3.56	6.58	1.04	3.74	6.69	1.04	3.79	6.38	0.08	3.52	5.94	0.87	3.34
Under 16 years	0.07	0.09	0.04*	0.04*	0.04	0.20	0.10	0.10	1.15	0.05	0.04	0.05	0.08	0.08	0.04
16-19 years	7.52	3.30	5.46	5.72	4.56	5.15	6.8	4.52	5.69	4.99	2.90	3.97	3.95	3.52	3.74
20-24 years	19.35	3.46	11.58	17.76	5.02	11.56	19.10	4.76	12.10	16.83	3.44	10.29	15.00	3.44	9.34
25 years and over	7.40	0.68	3.85	8.01	0.66	4.13	7.77	0.66	4.02	7.79	0.60	3.99	7.38	0.62	3.82
Late syphilis															
All ages	3.87	1.76	2.79	3.67	1.70	2.66	4.38	1.89	3.10	4.44	1.97	3.17	4.24	1.85	3.02
Congenital syphilis															
All ages	0.28	0.33	0.30	0.25	0.37	0.31	0.23	0.45	0.34	0.17	0.34	0.26	0.24	0.28	0.26
Gonorrhoea (post pubertal)															
All ages	163.91	89.60	125.79	164.70	92.23	127.54	161.38	89.94	124.73	154.67	85.84	119.36	155.40	86.64	120.14
Under 16 years	1.87	8.57	5.13	1.98	8.52	5.16	2.56	7.76	5.09	1.75	5.99	3.82	1.43	6.13	3.72
16-19 years	331.52	513.05	420.19	329.41	510.53	417.73	304.17	473.06	386.66	387.65	434.41	359.37	297.63	431.52	363.00
20-24 years	728.41	475.72	604.92	736.92	490.17	616.71	696.65	471.19	586.58	659.05	458.49	561.14	666.70	464.42	567.69
25 years and over	147.97	42.73	92.40	145.38	43.36	91.52	144.92	43.52	91.39	140.63	42.67	88.92	137.83	41.62	87.10
Chancroid															
All ages	0.03*	0.15	0.17	0.17	0.01*	0.09	0.19	0.02	0.10	0.20	0.02	0.11	0.19	0.03	0.11

*These rates were based on fewer than 10 events and consequently their reliability as a measure may be affected.

Source: British Journal of Venereal Diseases, vol.59,1983,p.134.

II. PROSTITUTION AND STD'S: RESEARCH IN THE U.S.A. AND IN THE U.K.

The 'Yes' Position

A number of learned articles state that prostitutes do make a significant contribution to the spread of venereal diseases (Conrad et al. 1981; Turner E.B., and Morton R.S. 1976; Frosner G.G. et al. 1975; Fanta D. et al. 1979; Seliborska Z. et al. 1979; Idsoe and Guthe 1967; Keighley 1960; and Potterat et al. 1979). For instance, in a recent article Conrad et al. (1981: 241) state the following:

"Our review of all the published studies we could find and our retrospective study of sexual offenders in Atlanta force us to disagree with Rosenthal and Vandow. We believe that prostitutes in some areas of the United States, as well as elsewhere in the world, still are major transmitters of gonorrhea and other sexually transmitted diseases."

Although this group of authors recognizes that prostitution does not make as large a contribution to the spread of STD's as it once was reported to have done, they believe the change is only a relative one:

" In epidemiological terms our findings show that the vector role of prostitutes continues undiminished. The alleged decline in their role is relative only and not real. They accounted for one in six of locally acquired gonococcal infections in heterosexual men" (Turner and Morton 1976:52)

The following table summarizes the results of studies undertaken by scientists who take this position.

TABLE V: Summary of Studies: The 'Yes' Position

Study	Type of prostitute	Locale	Comparison Group; other controls?	Time Period	Percentage with STD's	
					Pros.	Other
Wren 1967	Inmates	State prison New S. Wales	other inmates; yes	Jan.- June 1966	(G) 44% (S) 2%	4% 1%
Keighley 1960	Holloway Prison,	London	other inmates; yes age	1958	(G) 34%	4%
Conrad et al. 1981	sexual offenders prostitutes	Atlanta Georgia	no	1978 Sept-Dec.	(STD men) 44.1% (" women) 29.3% (G) 28.3%	
	prostitutes	Fresno County	no	76-77	(G) 19.8%	
Potterat et al. 1979	Street prostitute attending V.D. clinic	Colorado Springs USA	V.D. clinic patients; yes	1958-1977	(G) 29%	21%
					% of V.D. traced to prostitutes	
Turner et al. 1976	Street walkers	Sheffield Eng.	-	1960-1973	(G) 17.7%	
G stands for Gonorrhea S stands for syphilis STD stands for all sexually transmitted diseases						

The 'No Position

Those scientists who disagree, (Hart 1977; Darrow 1976; Willcox 1963; Neumann 1983; Dunlop et al. 1971; and Rosenthal 1958), use the following arguments to support their position:

- Prostitution is no longer a major contributor to the spread of STD's - the problem today is promiscuity;

"Years ago, they were a prime source of infection. Nowadays, however, prostitution is experiencing a business slump except in some special situations, such as in large cities and around army posts, particularly overseas. The competition by non-professionals and para-professionals is keenly felt by the regular pros and estimates range that from only 5 percent to 10 percent of the new cases of S.T.D. are being spread by prostitutes."
(Dr. Neumann 1983:155)

- Studies that assert that prostitution makes a significant contribution to the spread of STD's are methodologically inadequate (9).

The following table is a summary of the studies in this group.

TABLE VI: Summary of the 'No' Studies

	Type of prostitute	Local	Comparison Group; other controls?	Time Period	% of STD's traced to Prostitutes
Willcox 1962A 1962B*		U.K rural, urban Eng. & Wales	yes yes; no	1962 1954	15-19% 30%
1954			yes		30%
Dunlop et al. 1971		London	yes	1960 1969	31% 14%
Rosenthal et al. 1958		New York	yes yes	1946 1956	23.6% (G) 5.2% (G)
(*) Based on data collected by the British Clinical Co-operative Group (G) stands for gonorrhea					

9. As Willcox (1962A:37) states, "There is no sufficiently objective study to determine the place of prostitution in the spread of venereal disease, as compared with the spread of such diseases by girls of a lower social level who are not prostitutes. Until the total number of each in a population can be related to the male population at risk, and the cases of venereal diseases can be related to the number of exposures, this cannot be done."

The easiest way to settle this argument is to determine whether the studies, which take the 'yes' position are sound enough, from a methodological point of view, to warrant such a conclusion. If they are not, then these authors do not have the data to be able to come to any conclusion about whether prostitutes do or do not make a significant contribution to the spread of STD's.

Methodological problems

a) Misuse of the 'inductive method'

All of these studies are based upon the inductive method. Research is done on a small group of individuals and then generalizations are made to a larger group whether they were part of the research group or not. The major problem with this method is that if one is to make generalizations about prostitutes, then the group of prostitutes that one studies must be representative of all prostitutes. For instance, the streetwalker, the brothel prostitute, and the call girl span a wide spectrum of human types. Each may have a different likelihood of contracting STD's and spreading these diseases. One can not study streetwalkers and then use this data to come to conclusions about prostitutes in general.

An examination of the first table (Summary of Studies : The 'Yes' Position) indicates that most of these studies did not focus upon a group of prostitutes that are representative of all prostitutes. Most studies focus upon the streetwalker. Therefore, the data are seriously biased - most likely the prevalence of disease for the prostitute population as a whole is overestimated since it is believed that streetwalkers tend to have higher infection rates than do 'higher class' prostitutes.

As well, these studies focus upon a group of prostitutes living in a very specific location - usually in a prison or in a city like London. Since it is believed that STD's are more prevalent in large cities, especially seaport cities, than in small cities, these studies would again tend to overestimate infection rates.

In conclusion, these studies focus upon a particular type of prostitute, living in a particular locale, at a very specific point in time. The results of these studies should not be used to make conclusions about the prostitute population as a whole, especially when the type of prostitute and locale studied tend to overestimate the incidence of STD's.

b) Failure to control for factors that have an impact on infection rates

When researchers are faced with the prospect of having to study the effect of a factor, like a disease, on a particular group they should try to control for all factors that might bias their results such as age, sex, occupation, type of protection used to avoid STD's, etc. They will first identify all factors which might bias their results

and then they will try to rule out all of these threats to the validity of their results through the use of various methodological tools.

"In any geographic area, the number of prostitutes reported to have gonorrhea is a function of the frequency with which they are tested, the sensitivity and specificity of the diagnostic tests used, and the effectiveness of the therapy given, as well as of the number of unprotected exposures they have, the prevalence of disease in their partners, and the rates of transmission from hosts to susceptibles."
(Conrad et al. 1981:242)

For instance, Potterat et al. (1979) compared STD disease occurrence in a prostitute group with disease occurrence in a group of women who were not prostitutes. He was trying to prove that the prostitutes would be more likely to be infected than the women who were not prostitutes. Potterat was very careful to determine the racial composition and age of each of these groups. Although they were similar in terms of age they were not similar in terms of racial composition. Since the likelihood of catching an STD is dependent upon one's race, (Hooper et al. 1978), Potterat should have taken this factor into consideration when interpreting study results. Since he did not control for this factor, his findings are suspect because any difference found in the rate of infection in these two groups could be a result, not of their sexual habits, but rather a result of their racial differences.

Most of the above studies do not take into account that the prevalence or the incidence of a disease depends upon the number of times one is tested and treated for that disease. The better the testing and reporting procedures the higher the recorded incidence of a disease. Prostitutes who regularly attend V.D. clinics and receive treatment for an STD may report a higher incidence of the disease since reinfection can occur. However, if someone is not treated for the disease there is no risk of infection since infection has already occurred. For instance, the Potterat study noted that prostitutes, on average, make more routine visits to a local V.D. clinic than did members of the non-prostitute group they were being compared to; (31% of current prostitutes stated that they came to the VD clinic for a routine visit whereas only 11% of the comparison group made up of non-prostitutes came to the clinic for a routine visit.) This means that the differences that Potterat noted in infection rates for these two groups might simply be due to differences in the frequency with which the two groups visited the clinic and not to real differences in their likelihood of catching and spreading STD's.

If one evaluates these studies on their effort to rule out threats to making a valid inference about prostitutes in general one finds that they are all seriously lacking, even in the most basic controls. For example, most do not control for sex, age, race, risk of transmission,

prevalence of STD's in partners, and for type of prophylactic used. This means that any differences observed between prostitutes and non-prostitutes may simply be a result of differences in these factors and not a consequence of the sexual activities of prostitution.

c) Gaps in logic and a lack of objectivity

One rather surprising finding is that most of the studies that take the position that prostitutes make a significant contribution to the spread of STDs use a different measurement technique than those that take the opposite position. The former (the 'Yes' studies) measure the rate of infection of a particular group of prostitutes but they fail to make the logical step that the latter group takes. They do not try to quantify the contribution these infected prostitutes make to infecting customers as compared to the contribution infected women in general make to infections in males. The 'No' group of studies clearly shows that, at least for the prostitutes studied, about one in five STD infections are traced to prostitutes whereas the other four are traced to other groups, (i.e. casual acquaintances, friends, spouses and homosexuals.)

The 'Yes' studies suffer, therefore, from a serious gap in logic - they are not collecting the right type of data to allow them to conclude that prostitutes make a significant contribution to STD infections in male customers. The only exception to this statement is the Turner and Morton study (1976) which did try to link prostitutes to rates of infection in their customers.

As well, all of these studies, whether they take the 'yes' position or the 'no' position focus their attention on female prostitutes and females defined as 'non prostitutes'. The contribution males make to the spread of STD's is not compared to the contribution female prostitutes make to the spread of STD's. This is a serious gap in logic since males and females, whether they are defined as prostitutes or not, can be transmitters of STD's. As outlined earlier, official Canadian, American and British STD data reveals that young males between the ages of 20 and 24 have by far the highest incidence of STD of any age or sexual grouping. If they have the highest incidence of STD's, they might also be the group which makes the greatest contribution to the spread of STD's in Canada as well as in other countries. As Rothenberg notes, most studies focus upon prostitution because it is easy to do so, not because it is the most logical thing to do:

"Does this mean that prostitutes are bound to be important transmitters in all areas? The answer is no. As with gonococcal pelvic inflammatory disease, prostitution is a marker for potential importance. The message to gonorrhea control programs is clear: Keep looking, even if the light is not very good. Look to women with pelvic inflammatory disease, to prostitutes, to young military recruits, to the specific clientele of a specific private practitioner, to some groups of gay men, to individuals from a geographically defined area." (Rothenberg and Vandow 1958:94-99.)

Therefore, the failure to evaluate the contribution that other high risk groups make to the spread of STD's and compare it to the contribution prostitutes make to this problem, throws serious doubt upon the objectivity of all of these studies, whether they take the 'yes' position or the 'no' position.

d) Absence of criteria to determine the significance of the problem

These studies pose another problem in that the criteria used to prove or disprove their hypotheses are never clearly defined nor defended. For example, none of the 'Yes' studies state what infection rate would have to be achieved before one could conclude that prostitutes no longer make a significant contribution to the spread of STD's. The 'No' studies are also unclear on this point. At least, however, the 'No' studies give one an idea of the extent to which infected prostitutes infect their clients in comparison to other groups. However, clarification is still needed because the Turner and Morton study (1976) which found that 17% of gonorrhea in males could be linked to prostitutes, said that prostitutes were important transmitters of gonorrhea whereas the British Co-operative Clinical Group, (Willcox 1962B), noted higher rates but yet decided that the prostitute did not make an important contribution to this problem.

Conclusions

After having examined these studies we have come to the following conclusions:

- all of the studies we examined are methodologically flawed;
- prostitutes do not make as large a contribution to the spread of gonorrhea as do other females;
- we do not know how large a contribution prostitutes make to the spread of STD's in comparison to other high risk groups such as young males aged 20-24;
- streetwalkers, in some Western cities, are probably a high risk group since they tend to have a higher prevalence of gonorrhea than do other females; and

III. THE CONTROL OF STD'S IN PROSTITUTES

The major objective in controlling STD's in prostitutes has been to minimize the chances that they will spread these diseases to their customers. In the past, a number of options have been used. They usually fall into the following three main categories:

- registration of prostitutes usually accompanied by compulsory medical examinations;
- legislation permitting the arrest and compulsory treatment of prostitutes believed to have V.D.; and,
- voluntary programs run by local VD clinics which are not specifically directed at a prostitute clientele but which respect the special needs of the prostitute, accompanied by contact tracing, and identification and treatment of high risk groups.

We will examine each of these options in turn, and try to assess their reported effectiveness.

Registration of Prostitutes and Compulsory Medical Examinations

A typical example of this type of system is the Italian bordello as described by Lentino, (Lentino 1955). The type of system he evaluated was a licensed operation complete with a medical examination room. Information on how to prevent V.D. was posted on the walls for the information of all patrons. Every two weeks a blood serologic test was done for syphilis and a medical examination was done every two days for gonorrhea. When a woman was found to have V.D. she was given treatment and not allowed to work until fully recovered.

The police registered prostitutes and they inspected the houses. As well they checked medical records and accompanied any individual who believed they had caught V.D. from a prostitute.

Lentino reported that this method was ineffectual due to the difficulty of diagnosing venereal disease in women. He reported that 80% of V.D. in soldiers was traced to licensed brothels. Other studies have judged this type of system to be ineffectual as well, usually for the following reasons: it cannot control clandestine prostitutes; frequent medical examinations may provide a false sense of security for prostitutes, clients and controllers; frequent medical examinations may provoke hostility and decrease cooperation on the part of prostitutes, such a system almost inevitably corrupts the individuals who are charged with its supervision, (Hart 1977:59-61) ; and the standards of compulsory

medical examination vary and tend to deteriorate with time (10).

Apart from empirical data suggesting that this method is ineffectual it has another drawback - its human rights implications. The registration of prostitutes has been opposed on the grounds that it infringes upon the civil rights of the individual and is contrary to modern conceptions of humanity (Article 6 of the United Nations Resolution on Prostitution, 1950). Such a licencing mechanism labels a woman and makes it more difficult for her to become reestablished in a more 'respectable' occupation after she leaves prostitution. (Hart 1977:59)

"Growing concern for the alleged 'white slave trade' in women and girls led the League of Nations and later the United Nations to call for the abolition of licensed brothels, which were claimed to be the main sources of regular demand for the international commerce in women and girls. These international conventions, in conjunction with feminist arguments against the degree to which licensing unjustly regulated and stigmatized the lives of prostitutes, led to the abolition of state licensing in Europe." (Richards 1983:91)

Legislation permitting the arrest and/or compulsory examination of prostitutes and other persons believed to have VD

A number of examples exist of such a system: the U.K. Criminal Justice Act of 1948, Section 54-121 of the Fulton county Health Regulations (Georgia, U.S.A), Section 25-4-404, GS amended of the Colorado Revised Statutes, and all Canadian provincial and territorial venereal disease legislation.

10. "It has been shown that what benefit is derived from the routine regular medical examinations of prostitutes is obtained only at a very high cost. The procedure even when well done, it is argued, is not an economic proposition in relation to the results achieved...On the other hand, of female patients with gonorrhea, it has been indicated that prostitutes do comprise an appreciable proportion of the known reservoir of infection and it is logical that some effort should be made to control it. How to strike a proper balance remains the so far insoluble problem." (Willcox 1963:8)

In England, under the Criminal Justice Act of 1948 it was possible to send a woman to prison on remand for a physical and mental report if she was charged with an offence punishable by imprisonment.

In Canada, every province and territory has legislation to force people to be examined for V.D. In order to do this, public health officials have been given a great deal of power. According to Rozovsky (1982:71), this procedure removes rights that even those charged with serious criminal offences are guaranteed.

"In a criminal trial the onus is on the Crown prosecutor to prove the accusation, not simply to the satisfaction of the judge and jury, but beyond a reasonable doubt."

In Atlanta Georgia, under the Fulton County Health Regulations, everyone arrested for prostitution or other related sexual offenses is suspected of being infected with a sexually transmitted disease and must report for an examination at the Fulton County Health Department.

Conrad et al. (1981) studied the medical charts of persons arrested under this regulation and concluded that screening sexual offenders is an effective way of identifying untreated cases of sexually transmitted disease in the community. (Conrad 1981:244)

However, Conrad stopped short of recommending that compulsory programs or legislation, be adopted as a means to screening sexual offenders.

In Colorado, state, county and municipal health officers, may detain and make examinations of persons suspected of having V.D. Upon arrest, a prostitute is held in custody without bail until a health officer can make a ruling about the likelihood of V.D. Potterat et al.(1979) studied these control measures and compared them to voluntary programs. They found that compulsory measures such as legal orders were significantly less effective in finding gonorrhea in prostitutes than were prostitutes' routine visits to a clinic or contact tracing.

TABLE VII: Rates of Gonorrhea in Prostitutes Listed by Reason for Attendance at Venereal Disease Clinic

Reason for Clinic Visit	Past Prostitutes		Current Prostitutes	
	No.	%	No.	%
Routine	127/444	29	62/198	31
Legal order	37/203	18	17/79	22
Contact with gonorrhea	62/135	46	32/61	52
Follow-up	12/116	10	6/61	10
Total	247/910	27	125/402	31

Source: Potterat et al. 1979.

Public Health Programs, Contact Tracing and Identification of High Risk Groups

a) Education programs

Little information exists on the effectiveness of education programs (Sacks et al. 1983) especially programs for high risk groups such as prostitutes. However, a number of Canadian experts believe that increased education is important to the improved control of STD's.

" The development of educational programs will be vital in the fight to control sexually transmitted diseases. The goals of these programs should be to improve the therapy of the infected client and to have a positive impact at every level of control. With regard to STD education in this country, our analysis is that current education programs for all groups are inadequate. This conclusion is based not only upon our personal opinions but also on the opinions of several provincial venereal disease control directors who responded to a questionnaire that we distributed." (Sacks 1983:176)

b) Contact Tracing

Schofield (1979) states that the effectiveness of contact tracing depends upon the amount of accurate information that can be collected from the patient. This is particularly critical with highly promiscuous groups such as prostitutes.

"The success of the medico-social management of sexually transmitted diseases in any area depends on the faith the local promiscuous people, especially the highly promiscuous, have in the clinic staff. This faith takes a long time to build up and it can be lost quickly by the mismanagement of these patients. There must be no moralizing and they must be made to feel free to attend for a check-up at any time... " (Shofield 1979:28)

Certainly the Potterat study (Potterat et al. 1979) indicated that of all the methods used to control STD's in prostitutes, contract tracing located the most cases of gonorrhea in a Colorado clinic.

c) Identifying high risk groups

Jessamine et al. (1983) state that the increasing incidence in reported gonococcal infections in Canada indicates that current public health control programs are not effective. They suggest that the primary strategy for control should be contact tracing, case investigation, and identifying and locating sexual partners considered to be at highest risk. As well, they suggest that a self-referral system (11) might also be adopted as it has proven to be useful in Britain.

"While established contact tracing and case investigation efforts must be continued, additional resourcefulness should be concentrated on 2 groups. These are the "core" population responsible, directly or indirectly, for every gonococcal infection occurring in the community, and the asymptomatic male cases often infectious for prolonged periods of time, and now closely identified with gonococcal PID in their sexual partners." (Jessamine et al. 1983:164)

In order to identify high risk groups one should identify their sociological characteristics (12) and the area in which they can be found. However, attempts to control STD's which focus on special areas such as hotels and residential area must be conducted without disrupting the underlying social structure of the area, and without resorting to oppressive measures which would only serve to scatter infected people.

Conclusion

Many different measures can be used to control the spread of STD's by prostitutes. Traditionally, 'utilitarian' arguments have been used to justify compulsory V.D. programs for prostitutes. This theory argues

11. Patients are encouraged to inform their regular partners and to urge them to seek medical help.

12. According to Hart (1979) examination of individual factors such as race, age, marital status, education, intelligence, socioeconomic status, parental influence, alcoholic intake, and personal prophylaxis is of value in considering control policies.

that the 'useful' is the 'good' and that the determining consideration of 'right conduct' should be the usefulness of its consequences. Utilitarianism suggests that the aim of action should be the largest possible balance of pleasure over pain or the greatest happiness of the greatest number of people. Specifically, in this case, it takes the position that the overall health of society is more important than the suffering or inconvenience which might be caused by compulsory medical exams. In a recent television show (CBS, Sixty Minutes) it was argued that the arrest and detention of a prostitute who had AIDS was necessary for public health reasons despite the economic and personal hardships that would result for the prostitute and her dependents.

These utilitarian arguments can be disputed if one uses human rights arguments. For instance, one can argue that it is not fair that a prostitute who has AIDS is jailed when other AIDS victims who are not prostitutes are allowed to go free. Does this not deprive prostitutes, as citizens of a country, of certain inalienable human rights? Does this not just boil down to discrimination against a select group of people based upon their 'low' social status? As well, the human rights argument points to the question of equality within society. Why should the prostitute with AIDS have fewer rights than the client who infected the prostitute, or fewer rights than other AIDS patients. In sum, human rights arguments point to the discriminatory nature in which prostitutes are be treated in the name of 'public health'.

"Blaming someone else, usually women, for the spread of venereal disease is a phenomenon that in Britain had already been established by hounding prostitutes through the use of the Contagious Disease Acts. Clearly this tradition was successfully handed on to our colonial and North American allies, who could not conceive of their sons being anything but virginal or at worst the innocent party."
(Adler 1980:208)

Apart from the human rights question, the utilitarian argument is losing ground, especially where compulsory treatment programs or legislation is concerned, simply because these control measures are not particularly effective.

"Acceptance of the prostitute as an individual and interest in her physical and psychological needs may be expected to induce greater cooperation from her profession. Certainly little impact on the venereal disease problem can be expected without this cooperation."
(Hart 1977:172.)

This begs the question as to why we should support compulsory control measures when they do not attain utilitarian objectives (i.e. they do not protect public health), and when they infringe upon human rights? We conclude that of these three types of measures, only the voluntary programs are justified. Registration of prostitutes has been dropped on human rights grounds. Venereal disease legislation, similar

to the type we have in Canada, not only appears to be less effective than voluntary public health measures, (Potterat et al. 1979) but also poses serious human rights questions. We, therefore, conclude that the only measure which can be justified on both effectiveness and human rights grounds are voluntary STD programs.

DEFINITIONS AND NOTES

Antigen

Allergen; immunogen; any substance that, as a result of coming in contact with appropriate tissues of an animal body, induces a state of sensitivity and/or resistance to infection or toxic substances after a latent period (8 to 14 days) and when reacts in a demonstrable way with tissues and /or antibody of the sensitized subject. Source: Stedman's Medical Dictionary, Fifth Edition, Anderson's Publishing Company, 1982.

The Core Group

This concept posits the existence of small groups of individuals who, by virtue of their sociodemographic characteristics, life styles, sexual activities, and health care-seeking behaviors, are key transmitters of STD's both inside and outside their immediate sexual milieu. The hypothesis that all cases of a particular STD may be directly or indirectly attributable to this core is being explored. Potterat et al. suggest the possibility that prostitutes in Colorado prings may be such a group. It should not be assumed, however, that all prostitutes are key transmitters. Yorke et al. (1978), who defined the core group as being made up of groups having a high prevalence (20% or more) of a disease, states that all cases of gonorrhea are either directly or indirectly caused by the core.

Epidemiology

The study of the prevalence and spread of disease in a community. Source: Stedman's Medical Dictionary, Fifth Edition, Anderson's Publishing Company, 1982.

The infected pool

This pool consists of a diverse group of individuals, both men and women, both symptomatic and asymptomatic. The concept of the asymptomatic female pool (typically called the female reservoir of infection) has been, according to Hart a gross oversimplification. Present evidence suggests that symptomatic infection in the male may be almost as significant.

Prevalence

The number of cases of infection in a community at any moment in time or during a particular specified time period.

$$\text{PREVALENCE} = \text{INCIDENCE} \times \text{DURATION of the illness}$$

Given the relationship between incidence and duration the prevalence of a disease depends not only on the number of new cases but also on

the duration of the disease such that incidence may be low but if the disease is a chronic one prevalence may be high. For instance, in the case of asymptomatic gonorrhea in males there is a 1-3% incidence rate and a 20-50% prevalence rate (i.e. asymptomatic gonorrhea accounts for 1-3 percent of all male gonococcal infections, whereas at any given time 20 to 50 percent of all male gonococcal infections are asymptomatic. (Hart, 1977.)

The Promiscuity Argument

Prostitutes have traditionally been considered to be a high risk population. Common sense would seem to dictate that they have a greater likelihood than other groups of catching and spreading STD's since, in general, they are more promiscuous than other groups. The hypothesis underlying the promiscuity argument is that the greater the number of sexual partners within a given time period, the higher the transmission rate of STD's. This hypothesis may not hold since it has been shown (Darrow, 1976) that the relationship between number of partners and number of venereal infections is not always linear, nor is it conclusive.

Hooper et al. (1978) found a statistically significant relationship between the risk of transmission of gonorrhea and both the number of partners and the frequency of sexual intercourse for men. Unfortunately, Hooper does not publish the risk of transmission for more than three exposures whereas Darrow does. Since some prostitutes would have more than three exposures per day, Hooper's data does not tell us whether the risk of transmission levels off after a certain number of exposures.

Prostitutes

Most of the studies done on the relationship between prostitution and STD's define prostitutes as someone, usually a woman, who sells sexual favours for money.

Sexually Transmitted Diseases

This term has replaced the term venereal diseases in the literature. V.D. or venereal disease usually refers to the following infections: gonorrhea, syphilis, chancroid, granuloma inguinale and lymphogranuloma venereum. STD's refers to these infections plus non-gonococcal urethritis, herpes genitalis, trichomoniasis, AIDS, candidiasis, molluscum contagiosum, pediculosis (pubic lice), scabies ('the itch'), genital warts, type B viral hepatitis, and intestinal parasites. Not all STD's are caught through sexual contact. For instance, pubic lice can be caught by coming in contact with bed clothes infested with the lice. (Meltzer 1981:1)

Risk of Transmission

Risk of transmission refers to the likelihood of acquiring a particular STD through sexual contact with an infected partner. Rates vary according to a number of variables such as race and sex. Hooper et al. (1978) found a statistically significant relationship between the risk of transmission of gonorrhea and both the number of partners and the frequency of sexual intercourse. The calculated risk of transmission per exposure with an infected partner was .19 for white males and .53 for black males.

Venereal Disease

See the definition of sexually transmitted diseases.

BIBLIOGRAPHY

Adler, M.W. The terrible peril: a historical perspective on the venereal diseases, British Medical Journal, July, 19, 1980, p. 206-211.

Catterall, R.D., and Nicol, C.S. Sexually Transmitted Diseases, Academic Press, London, 1976.

Cini, Maltaise, Prostitution and Venereal Disease, 1983, (unpublished document).

Conrad, G.L., et al. Sexually Transmitted Diseases among Prostitutes and Other Sexual Offenders, Sexually Transmitted Diseases, vol. 8, no. 4, 1981, p. 241-243.

Darrow, William. Changes in Sexual Behavior and Venereal Diseases, Clinical Obstetrics & Gynecology, vol.18, 1975, p. 255-267.

Darrow, William. Approaches to the Problem of Venereal Disease Prevention, Preventive Medicine, vol. 5, 1976. p. 165-175.

Darrow, William. Venereal Disease and Victimless Crime, Conference of the Society for the Study of Social Problems, 1978.

Dunlop, E.M., Lamb, A.M., and King, D.M. Improved Tracing of Contacts of Heterosexual Men with Gonorrhoea, Relationship of altered female to male ratios, British Journal of Venereal Disease, vol. 47, 1971, p. 192-195.

Evans, R.J. Prostitution, State and Society in Imperial Germany, Past & Present, vol. 70, 1976, p. 106-128.

Hart, Gavin. Sexual Maladjustment and Disease: An Introduction to Modern Venereology, Nelson-Hall, Chicago, 1977.

Health and Welfare Canada. Sexually Transmitted Diseases in Canada 1982, Bureau of Epidemiology, Laboratory Centre for Disease Control, Health Protection Branch, 1983.

Health and Welfare Canada. Canada Diseases Weekly Report, vol. 10-13, March 31, 1984.

Holmes, King; Johnson, David; Trostle, Henry. An Estimate of the Risk of Men Acquiring Gonorrhea by Sexual Contract with Infected Females, American Journal of Epidemiology, vol. 91, no. 2, 1970, p. 170-174.

Hooper, R.R., et al. Cohort Study of Venereal Disease: The Risk of Gonorrhea Transmission from Infected Women to Men, American Journal of Epidemiology, vol.108, no.2, p. 136-144.

Idsoe, O., and Guthhe, T. The Rise and Fall of the Treponematoses; Ecological Aspects and International Trends in Venereal Syphilis, British Journal of Venereal Disease, vol. 43, 1967, p. 227-243.

Jessamine, A.G., Mathias, R., Sutherland, R. Epidemiology and Control of Sexually Transmitted Diseases, Canadian Journal of Public Health, vol. 74, no. 3, 1983, p. 163-166.

Judson, F.N., et al. Comparative Prevalence Rates of Sexually Transmitted Diseases in Heterosexual and Homosexual Men, American Journal of Epidemiology, vol. 112, no. 6, 1980, p. 836-843.

Keighley, Elizabeth. Venereal Disease among Women Prisoners, The Lancet, vol. 7, 1960, p. 253-254.

King, Ambrose. Venereal Disease Problems and Adolescent Health, Clinical Pediatrics, vol. 5, 1966, p. 597-603.

Knox, Samuel, R., Mandel, Bea; Lazarowicz, Remy. Profile of Callers to the VD National Hotline, Sexually Transmitted Diseases, October-December 1981, p. 245-254.

Lentino, Walter. Medical Evaluation of a System of Legalized Prostitution, JAMA, vol. 158, 1955, p. 20-23.

Meltzer, Alan S., Sexually Transmitted Diseases, Eden Press Incorporated, Westmount Quebec and St. Albans, Vermont, 1981.

Pellegrin, M. Etude de la Morbidité Vénérienne dans les Alpes-Maritimes, La Prophylaxie Sanitaire et Morale, vol. 7, July 1966, p. 199-211.

Post, J.B. A Foreign Office Survey of Venereal Disease and Prostitution Control, 1869-70, Medical History, vol. 22, 1978, 327-334.

Potterat, J. et al. Gonorrhea in Street Prostitutes: Epidemiologic and Legal Implications, Sexually Transmitted Diseases, vol. 2, 1979, p. 58-63.

Richards David. Sex, Drugs, Death, and the Law, Rowman and Littlefield, New Jersey, 1983.

Romanowski, Barabara B. Sexually Transmitted Diseases: A Time for Action, Canadian Journal of Public Health, vol. 74, no. 3, 1983, p. 153-157.

Romanowski, B., Meltzer, A.S., Rush, J. Treatment Guidelines for Selected Sexually Transmitted Diseases, Canadian Journal of Public Health, vol. 74, no. 3, 1983, p. 166-173.

Ronald, A.R., et al. Research on Sexually Transmitted Diseases in Canada, Canadian Journal of Public Health, vol. 74, no. 3, 1983, 173-177.

Rosenthal T., Vandow J. Prevalence of venereal disease in prostitutes, British Journal of Venereal Disease, vol. 34, 1958, p. 94-9.

Rozovsky, L.E. and F.A. Legal Sex, Doubleday Canada Limited, Toronto, 1982.

Sacks, S.L., Bowie, W.R., Stayner, M. Education and Public Awareness of Sexually Transmitted Diseases, Canadian Journal of Public Health, vol.74, no. 3, 1983, p. 176-179.

Sgroi, Suzanne. Pediatric Gonorrhea and Child Sexual Abuse: The Venereal Disease Connection, Sexually Transmitted Diseases, July-September 1982, p. 154-156.

Schofield, C.B.S. Sexually Transmitted Diseases, Churchill Livingstone, New York, 1979.

Turner, B., Morton, R.S. Prostitution in Sheffield, British Journal of Venereal Disease, vol. 52, 1976, p. 197-203.

Yorke, J.A., Hethcote, H.W., Nold, A. Dynamics and Control of the Transmission of Gonorrhea, Sexually Transmitted Diseases, vol. 5, 1978, p. 51-56.

Willcox, R.R. Prostitution and Venereal Disease: Proportion of Venereal Disease Acquired from Prostitutes in Asia: A Comparison with France, the United Kingdom, and the United States of America, British Journal of Venereal Disease, vol. 38, 1962A, p. 37-42.

Willcox, R.R. Factors Leading to a Failure of Control of Gonorrhoea, British Journal of Preventive Social Medicine, vol. 16, 1962B, p. 113-122.

Willcox, R.R. Prostitution and Venereal Disease: Medical 'Control' of Prostitutes', Antiseptic, vol. 60, 1963, p. 6-14.

World Health Organization, Venereal Disease Control: A Survey of Recent Legislation, Geneva, 1975.

Wren, Barry, G. Gonorrhoea among Prostitutes, The Medical Journal of Australia, vol. 5, 1967, 847-849.

Appendice I

Selected National and International STD Legislation

Source: World Health Organization, Venereal Disease Control, 1975.

Legislation

Argentina

Law No. 15465 of 24 October 1960 making compulsory, throughout the territory of the Nation, the notification of cases of infectious disease (see *Int. Dig. Hlth Leg.*, 1961, 12, 677)

subsequent Acts; and for purposes connected therewith. Dated 15 October 1963. (The Venereal Diseases (Amendment) Act, 1963) (see *Int. Dig. Hlth Leg.*, 1966, 17, 415)

Venereal Diseases Act, 1918, as amended.—Regulations. Dated 5 June 1964 (see *ibid.*)

Australia

New South Wales

An Act (No. 37 of 1963) to make provision for the medical examination of persons suffering or suspected to be suffering from venereal disease; for these and other purposes to amend the Venereal Diseases Act, 1918, as amended by

Tasmania

An Act to consolidate and amend the law relating to public health. No. 75 of 1962. Dated 14 February 1963. (The Public Health Act 1962) (see *Int. Dig. Hlth Leg.*, 1965, 16, 14)

Public Health (Venereal Diseases) Regulations 1966. Serial No. 102 of

1966. Dated 24 May 1966 (see *ibid.*, 1968, 19, 693)

An Act (No. 35 of 1966) to amend the Public Health Act 1952. Dated 11 November 1966. (The Public Health Act 1966) (see *ibid.*, 695)

Brazil

Decree No. 4997-A of 21 January 1961 regulating under the name of the National Health Code Law No. 2312 of 3 September 1954 embodying general provisions for the defence and protection of health (see *Int. Dig. Hlth Leg.*, 1962, 13, 607)

Bulgaria

Decree No. 225 of 16 March 1968 to promulgate the Family Code (see *Int. Dig. Hlth Leg.*, 1970, 21, 533)

Order No. 2247 of the Minister of Public Health and Social Welfare with regard to the prenuptial certificate of health (see *ibid.*)

Regulations for the implementation of the Law on public health (approved by Resolution No. 23 of 23 March 1974) (see *ibid.*, 1974, 25, 520)

Canada

Alberta

Alberta Regulation No. 492/61 of 28 December 1961 governing the control of communicable disease (see *Int. Dig. Hlth Leg.*, 1962, 13, 643)

The Venereal Diseases Prevention Act, 1965 (see *ibid.*, 1966, 17, 21)

Manitoba

Manitoba Regulation 120/68. A Regulation under The Public Health Act to amend Manitoba Regulation 91/45 (see *Int. Dig. Hlth Leg.*, 1971, 22, 80)

Manitoba Regulation 51/70. A Regulation under The Public Health Act to amend Manitoba Regulation

91/45. Dated 26 March 1970 (see *ibid.*, 1973, 24, 49)

Colombia

Decree No. 393 of 26 February 1963 enacting certain regulations concerning the notification of communicable diseases (see *Int. Dig. Hlth Leg.*, 1964, 15, 71)

Decree No. 239 of 10 February 1965 to repeal Decree No. 158 of 31 January 1964 and to replace it by other provisions for the implementation of Section 66 of Decree No. 3224 of 1965 (see *ibid.*, 1967, 18, 303)

Costa Rica

Decree No. 4573 of 4 May 1970 embodying the Penal Code (see *Int. Dig. Hlth Leg.*, 1975, 26, 61)

Cuba

Ministerial Decree (Public Health) No. 7 of 16 March 1962 embodying regulations with regard to international health and to the national health services (see *Int. Dig. Hlth Leg.*, 1963, 14, 12)

Czechoslovakia

Instruction No. 30 of 17 December 1968 of the Ministry of Health prescribing measures against venereal diseases (see *Int. Dig. Hlth Leg.*, 1969, 20, 429)

Denmark

Order No. 21 of 22 January 1962 with regard to the control of venereal diseases in Greenland (see *Int. Dig. Hlth Leg.*, 1964, 15, 103)

Law No. 287 of 23 May 1973 on the control of venereal diseases (see *ibid.*, 1973, 24, 753)

Circular of 28 June 1973 of the National Health Service on the co-operation of physicians in the field of venereal disease control (see *ibid.*, 1975, 26, 91)

Circular of 28 June 1973 of the Minister of the Interior embodying guidelines on the organization of venereal disease control in accordance with Law No. 287 of 23 May 1973 (see *ibid.*, 92)

Fiji

Pure Food Regulations, 1961. Legal Notice No. 85. Dated 16 June 1961 (see *Int. Dig. Hlth Leg.*, 1964, 15, 410)

An Ordinance (No. 10 of 1964) to amend the Public Health Ordinance. (The Public Health (Amendment) Ordinance, 1964). Dated 21 May 1964 (see *ibid.*, 1968, 19, 188)

France

Ordinance No. 60-1246 of 25 November 1960 amending and supplementing the provisions of Chapter I of Part II of Volume III of the Public Health Code (see *Int. Dig. Hlth Leg.*, 1961, 12, 529)

Decree No. 64-931 of 3 September 1964 to amend and supplement Decree No. 62-840 of 19 July 1962 relating to maternal and infant welfare (see *ibid.*, 1965, 16, 103)

Order of 27 August 1971 of the Minister of Public Health and Social Security and the Secretary of State for Social Welfare and Rehabilitation concerning prenatal and postnatal medical examinations (see *ibid.*, 1972, 23, 77)

German Democratic Republic

Ordinance of 23 February 1961 on the prevention and control of venereal diseases (see *Int. Dig. Hlth Leg.*, 1962, 13, 687)

Germany, Federal Republic of

Law of 25 August 1969 to amend the Law on the control of venereal diseases (see *Int. Dig. Hlth Leg.*, 1970, 21, 286)

Greece

Law No. 3310 of 13 July 1955 on the control of venereal disease, and matters related thereto (see *Int. Dig. Hlth Leg.*, 1958, 9, 511)

Guatemala

Decree No. 17-73 of 5 July 1973 to promulgate the Penal Code (see *Int. Dig. Hlth Leg.*, 1974, 25, 786)

Hungary

Ordinance No. 9 of 27 June 1972 of the Minister of Health for the implementation of the provisions of Law No. II of 1972 on health relating to epidemiology (see *Int. Dig. Hlth Leg.*, 1973, 24, 808)

Ordinance No. 12 of 11 July 1972 of the Minister of Health concerning the medical examinations of workers and the expert appraisal of working (professional) capacity (see *ibid.*, 825)

Ordinance No. 15 of 5 August 1972 of the Minister of Health for the implementation of the provisions of Law No. II of 1972 on health relating to therapeutic and prophylactic care (see *ibid.*, 828)

Israel

The Public Health (Infectious Diseases) Order, 1960. Dated 24 November 1960 (see *Int. Dig. Hlth Leg.*, 1961, 12, 772)

Italy

Law No. 837 of 25 July 1956 to reform the existing legislation relating to the prevention of venereal diseases (see *Int. Dig. Hlth Leg.*, 1957, 8, 496)

Decree No. 2056 of the President of the Republic dated 27 October 1962 for the enforcement of Law No. 837 of 25 July 1956 to reform the existing legislation relating to the prevention of venereal disease (see *ibid.*, 1963, 14, 637)

Luxembourg

- Law of 19 December 1972 introducing a medical examination before marriage and amending Sections 63, 75, and 109 of the Civil Code (see *Int. Dig. Hlth Leg.*, 1973, 24, 881)
- Regulations of the Grand Duke of 14 March 1973 specifying the examinations to be performed for the issue of a medical certificate before marriage (see *ibid.*)

Madagascar

- Decree No. 67-032 of 17 January 1967 specifying the procedure for the control of venereal diseases (see *Int. Dig. Hlth Leg.*, 1968, 19, 208)

Mexico

- Decree of 19 November 1969 prescribing the conditions to be fulfilled for the issue of the prenuptial medical certificate referred to in Section 90 of the Health Code of the United Mexican States (see *Int. Dig. Hlth Leg.*, 1972, 23, 214)

New Zealand

- The Health Act 1956. No. 65 of 1956. Dated 25 October 1956 (see *Int. Dig. Hlth Leg.*, 1957, 8, 643)
- An Act to amend the Health Act 1956. No. 76 of 1962. Dated 6 December 1962 (see *ibid.*, 1964, 5, 124)
- The Venereal Diseases Regulations 1964. Serial No. 209 of 1964. Dated 16 December 1964 (see *ibid.*, 1965, 16, 367)

Poland

- Ordinance No. 276 of 29 August 1958 of the Minister of Health concerning occupations forbidden to persons suffering from venereal diseases (see *Int. Dig. Hlth Leg.*, 1960, 11, 342)
- Ordinance of 2 September 1964 of the Minister of Health and Social Welfare with regard to medical exa-

minations for the detection of cases of venereal disease (see *ibid.*, 1965, 16, 729)

- Ordinance of 20 February 1971 of the Minister of Health and Social Welfare concerning the co-operation of State institutions and agencies and social organizations in the field of venereal disease control (see *ibid.*, 1973, 24, 374)

Romania

- Instructions No. XII/C1/2758 of 24 July 1971 concerning the prevention and control of venereal diseases (see *Int. Dig. Hlth Leg.*, 1972, 23, 318)

Senegal

- Decree No. 62-0317 M.S.A.S. of 16 August 1962 to organize the control of venereal diseases (see *Int. Dig. Hlth Leg.*, 1964, 15, 828)

Spain

- Decree of 4 July 1958 to approve the Regulations for the control of leprosy, venereal diseases, and dermatoses (see *Int. Dig. Hlth Leg.*, 1959, 10, 392)

Sweden

- Law No. 231 of 26 April 1968. (The Communicable Diseases Law) (see *Int. Dig. Hlth Leg.*, 1969, 20, 136)
- Crown Order No. 234 of 26 April 1968 on the control of communicable diseases. (The Communicable Diseases Order) (see *ibid.*, 142)

- Circular of 9 September 1970 of the National Board of Health and Welfare concerning measures to prevent gonorrhoea (see *ibid.*, 1972, 23, 345)

Switzerland

- Ordinance of 17 June 1974 on the notification of communicable diseases in man (Section 5) (see *Int. Dig. Hlth Leg.*, 1975, 26, 204)

Tunisia

Law No. 64-46 of 3 November 1964 instituting a prenuptial certificate (see *Int. Dig. Hlth Leg.*, 1966, 17, 396)

United States of America*West Virginia*

Act of 2 March 1959 to amend Section 6, Article 1, Chapter 48 of the Code of West Virginia, 1931, as amended, relating to application for an issuance of marriage license (see *Int. Dig. Hlth Leg.*, 1962, 13, 186)

Upper Volta

Order No. 71-46 SP.P.AS. of 16 February 1971 of the Minister of Public Health, Population and Social Affairs establishing the list of diseases subject to compulsory or optional notification (see *Int. Dig. Hlth Leg.*, 1973, 24, 674)

Yugoslavia

Decree of 28 December 1973 to promulgate the Law on the protection of the population against communicable diseases representing a threat to the country as a whole (see *Int. Dig. Hlth Leg.*, 1974, 25, 866)

Criminal Code of Canada

the Person Act, 1861, which was virtually the same as former s. 238 [now s. 252] of the Criminal Code: "The question is, whether or not the intention of any other person besides the defendant himself, that the poison or noxious thing should be used to procure a miscarriage, is necessary to constitute the offence charged under the 24 and 25 Vict. c. 100, s. 59. We are all of the opinion that that question must be answered in the negative. The statute is directed against the supplying or procuring of poison or noxious things for the purpose of procuring abortion with the intention that they shall be so employed, and knowing that it is intended that they shall be so employed. The defendant knew what his own intention was, and that was, that the substance procured by him should be employed with intent to procure miscarriage. The case is therefore within the words of the Act." *R. v. Hillman*, *supra*, was followed in *R. v. Titley* (1880), 14 Cox. C.C. 502 (U.K.) and in *Irwin v. R.* (1968), 3 C.R.N.S. 377 (S.C.C.).

252§5 Evidence — Dying declaration. Where there are two counts in the indictment, one charging homicide, and the other for administering and supplying drugs, and a dying declaration is admitted in evidence, the judge must instruct the jury that the declaration must be disregarded except on the charge of manslaughter: *R. v. Inkster* (1915), 24 C.C.C. 294 (Sask. C.A.).

Venereal Diseases

Venereal disease — Defence — Corroboration — "Venereal disease".

253. (1) Every one who, having venereal disease in a communicable form, communicates it to another person is guilty of an offence punishable on summary conviction.

(2) No person shall be convicted of an offence under this section where he proves that he had reasonable grounds to believe and did believe that he did not have venereal disease in a communicable form at the time the offence is alleged to have been committed.

(3) No person shall be convicted of an offence under this section upon the evidence of only one witness, unless the evidence of that witness is corroborated in a material particular by evidence that implicates the accused.

(4) For the purposes of this section, "venereal disease" means syphilis, gonorrhea or soft chancre.

253 History. Formerly 1953-54, c. 51, s. 239; 1927, c. 36, s. 307; 1906, c. 146, s. 316A [en. 1919, c. 46, s. 8].

253 Related sections. Code ss. 202-204 — Criminal negligence; 720 — Definitions; 722(1) — General penalty; 722(3) — Time for payment; 722(4) — What to be considered; 722(5) — What to be considered; 722(6) — Warrant of committal; 722(7) — Reasons for committal; 722(8) — Surrender by accused; 722(9) — Young offenders; 722(10) — Extension of time; 722(11) — "Fine"; 744 — Costs.

253 Related statutes. Interpretation Act, R.S.C. 1970, c. I-23, s. 27.

253§1 Communicating diseases. This section was first enacted as s. 316A in 1919. Before that time, it was not criminal to communicate any form of disease, including venereal disease: *R. v. Clarence* (1888), 22 Q.B.D. 23 (U.K. C.C.R.). Since the enactment, making it an offence to communicate these diseases, it was held that if death resulted from a venereal disease communicated by accused, he would be guilty of manslaughter: *R. v. Leaf* (1926), 45 C.C.C. 236 (Sask. C.A.).

Offences Against Conjugal Rights

Bigamy — Matters of defence — Incompetency no defence — Validity presumed — Act or omission by accused.

- 254.** (1) Every one commits bigamy who
- (a) in Canada,
 - (i) being married, goes through a form of marriage with another person,
 - (ii) knowing that another person is married, goes through a form of marriage with that person, or
 - (iii) on the same day or simultaneously, goes through a form of marriage with more than one person; or
 - (b) being a Canadian citizen resident in Canada leaves Canada with intent to do anything mentioned in subparagraphs (a)(i) to (iii), and, pursuant thereto, does outside Canada anything mentioned in those subparagraphs in circumstances mentioned therein.
- (2) No person commits bigamy by going through a form of marriage if
- (a) that person in good faith and on reasonable grounds believes that his spouse is dead,
 - (b) the spouse of that person has been continuously absent from him for seven years immediately preceding the time when he goes through the form of marriage, unless he knew that his spouse was alive at any time during those seven years,
 - (c) that person has been divorced from the bond of the first marriage, or
 - (d) the former marriage has been declared void by a court of competent jurisdiction.
- (3) Where a person is alleged to have committed bigamy, it is not a defence that the parties would, if unmarried, have been incompetent to contract marriage under the law of the place where the offence is alleged to have been committed.
- (4) Every marriage or form of marriage shall, for the purpose of this section, be deemed to be valid unless the accused establishes that it was invalid.
- (5) No act or omission on the part of an accused who is charged with bigamy invalidates a marriage or form of marriage that is otherwise valid.

254 History. Formerly 1953-54, c. 51, s. 240; 1927, c. 36, s. 308; 1906, c. 146, s. 307; 1892, c. 29, s. 275.

Sir James Clarke's Female Pills, with direction to take twenty-five at a dose, and that it would have that effect. In that number of pills there was sufficient oil of savin, an article used to procure abortion, to be greatly irritating to a pregnant woman and perhaps to cause an abortion. Held, that A supplied a noxious thing with the statute; *R. v. Stitt*, 30 U.C.C.P. 30.

³ *R. v. Hillman*, L. & C. 343.

Criminal Code, 1892, c. 29.

Supplying means of procuring abortion.

274. Every one is guilty of an indictable offence and liable to two years' imprisonment who unlawfully supplies or procures any drug or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she is or is not with child.

Criminal Code, R.S.C. 1906, c. 146.

Section 274 was re-enacted unchanged as section 305.

Criminal Code, R.S.C. 1927, c. 36.

Section 305 was re-enacted unchanged as section 305.

Criminal Code, 1953-54, c. 51.

Section 305 was re-enacted as section 238 using the wording which is now contained in R.S.C. 1970, c. C-34, s. 252.

Criminal Code, R.S.C. 1970, c. C-34.

Section 238 was re-enacted unchanged as section 252.

VENEREAL DISEASE — SECTION 253

An Act to amend the Criminal Code, 1919, c. 46.

The Criminal Code was amended by 1919, c. 46, s. 8 by inserting immediately after section 316 the following section:

Communicating venereal disease.

316A. (1) Any person who is suffering from venereal disease in a communicable form, who knowingly or by culpable negligence communicates such venereal disease to any other person shall be guilty of an offence, and shall be liable upon summary conviction to a fine not exceeding five hundred dollars or to imprisonment for any term not exceeding six months, or to both fine and imprisonment.

Provided that a person shall not be convicted under this section if he proves that he had reasonable grounds to believe that he was free from venereal disease in a communicable form at the time the alleged offence was committed.

Provided, also, that no person shall be convicted of any offence under this section upon the evidence of one witness, unless the evidence of such witness be corroborated in some material particular by evidence implicating the accused.

(2) for the purposes of this section, "venereal disease" means syphilis, gonorrhea, or soft chancre.

Criminal Code, R.S.C. 1927, c. 36.

Section 316A was re-enacted unchanged as section 307.

Criminal Code, 1953-54, c. 51

Section 307 was re-enacted as section 239 using the wording which is now contained in R.S.C. 1970, c. C-34, s. 253.

Criminal Code, R.S.C. 1970, c. C-34.

Section 239 was re-enacted unchanged as section 253.

DEFINITION OF BIGAMY — SECTION 254

Burbridge — Digest of the Criminal Law of Canada.

¹Definition and punishment of bigamy

²**Article 330.** ³Every one is guilty of the felony called bigamy and liable to seven years' imprisonment who, being married, marries any other person during the life of the former husband or wife, whether the second marriage takes place in Canada, or elsewhere.

[The expression "being married" means being legally married. The word "marries" means goes through a form of marriage which the ⁴law of the place where such form is used recognizes as binding, whether the parties are by that law competent to contract marriage or not, and although by their fraud the form employed may, apart from the bigamy, have been insufficient to constitute a binding marriage.]

Nothing in this Article extends to—

(a.) ⁵any second marriage contracted elsewhere than in Canada by any other than a subject of Her Majesty resident in Canada and leaving the same with intent to commit the offence;

(b.) ⁶any person marrying a second time whose husband or wife has been continually absent from such person for the space of seven years then last past, and who was not known by such person to be living within that time;

(c.) ⁷any person who, at the time of such second marriage, was divorced from the bond of the first marriage; or

(d.) any person whose former marriage has been declared void by the sentence of any court of competent jurisdiction.

⁸A person who marries again during his wife's or her husband's lifetime, but in the honest belief on reasonable grounds that she or he is dead, is not guilty of bigamy.

	that the death of, or bodily harm to, the hostage will be caused or that the confinement, imprisonment or detention of the hostage will be continued	b) de quelque façon, menace de causer la mort de l'otage ou de le blesser, ou de continuer à le séquestrer, l'emprisonner ou le retenir de force
	with intent to induce any person, other than the hostage, or any group of persons or any state or international or intergovernmental organization to commit or cause to be committed any act or omission as a condition, whether express or implied, of the release of the hostage.	dans l'intention d'amener une personne autre que l'otage, ou un groupe de personnes, un État ou une organisation internationale ou intergouvernementale à faire ou à omettre de faire quelque chose comme condition, expresse ou implicite, de la libération de l'otage.
Punishment	(2) Every one who takes a person hostage is guilty of an indictable offence and is liable to imprisonment for life.	(2) Quiconque se livre à une prise d'otage est coupable d'un acte criminel et est passible de l'emprisonnement à perpétuité.
Non-resistance	(3) Subsection 247(3) applies to proceedings under this section as if the offence under this section were an offence under section 247."	(3) Le paragraphe 247(3) s'applique aux procédures intentées en vertu du présent article comme si l'infraction que ce dernier prévoit était celle que prévoit l'article 247."
	(2) The said Act is further amended in the manner and to the extent set out in Schedule I.	(2) La même loi est en outre modifiée de la façon et dans la mesure exposées à l'annexe I.
	50. Section 253 of the said Act is repealed.	50. L'article 253 de la même loi est abrogé.
	51. The definition "document" in section 282 of the said Act is repealed and the following substituted therefor:	51. La définition de «document» à l'article 282 de la même loi est abrogée et remplacée par ce qui suit :
"credit card" «carte de crédit»	"credit card" means any card, plate, coupon book or other device issued or otherwise distributed for the purpose of being used upon presentation to obtain credit money, goods, services or any other thing of value;	«carte de crédit» désigne notamment les cartes, plaquettes ou coupons délivrés afin de procurer à crédit, sur présentation, des fonds, des marchandises, des services ou toute autre chose de valeur;
"document" «document»	"document" means any paper, parchment or other material used for writing or printing, marked with matter capable of being read, and includes a credit card, but does not include trade marks on articles of commerce or inscriptions on stone or metal or other like material;"	«document» signifie tout papier, parchemin ou autre matière employée pour l'écriture ou l'imprimerie, marquée d'une chose capable d'être lue y compris une carte de crédit, mais ne comprend pas les marques de commerce sur des articles de commerce, ni les inscriptions sur la pierre ou le métal ou autre matière semblable;»
1974-75-76, c. 93, s. 25	52. (1) Paragraph 294(a) of the said Act is repealed and the following substituted therefor:	52. (1) L'alinéa 294a) de la même loi est abrogé et remplacé par ce qui suit :
	"(a) is guilty of an indictable offence and is liable to imprisonment for ten	«a) est coupable d'un acte criminel et est passible d'un emprisonnement de dix

(2) These amendments are consequential on the new offence proposed by subclause (1).

Clause 50: This amendment would recognize venereal disease to be a health problem rather than a crime.

Section 253 reads as follows:

"253. (1) Every one who, having venereal disease in a communicable form, communicates it to another person is guilty of an offence punishable on summary conviction.

(2) No person shall be convicted of an offence under this section where he proves that he had reasonable grounds to believe and did believe that he did not have venereal disease in a communicable form at the time the offence is alleged to have been committed.

(3) No person shall be convicted of an offence under this section upon the evidence of only one witness, unless the evidence of that witness is corroborated in a material particular by evidence that implicates the accused.

(4) For the purposes of this section, "venereal disease" means syphilis, gonorrhea or soft chancre."

Clause 51: This amendment would add the definition "credit card" taken from the present subsection 301.1(3) and, in the definition "document", would add the underlined words to make it clear that the definition "document" includes "credit cards".

Clause 52: These amendments, which would substitute the underlined amount for the amount of "two hundred dollars", are consequential on the amendment to section 483 proposed by clause 114.

(2). — Découlent de la nouvelle infraction créée au paragraphe (1).

Article 50. — Reconnaît le fait que les maladies vénériennes sont un problème de santé et non un crime.

Texte actuel de l'article 253 :

"253. (1) Est coupable d'une infraction punissable sur déclaration sommaire de culpabilité, quiconque, étant atteint d'une maladie vénérienne transmissible, la communique à une autre personne.

(2) Nul ne doit être déclaré coupable d'une infraction visée par le présent article s'il prouve qu'il avait raisonnablement lieu de croire, et croyait effectivement, qu'il n'était pas atteint d'une maladie vénérienne transmissible à l'époque où l'infraction aurait été commise.

(3) Nul ne doit être déclaré coupable d'une infraction prévue au présent article sur la déposition d'un seul témoin, à moins que la déposition de ce témoin ne soit corroborée sous un rapport essentiel par une preuve qui implique le prévenu.

(4) Aux fins du présent article, l'expression «maladie vénérienne» signifie la syphilis, la gonorrhée ou le chancre mou.»

Article 51. — Adjonction de la définition de «carte de crédit» prise au paragraphe 301.1(3) actuel, et adjonction des mots soulignés à la définition de «document» pour établir clairement que la définition de «document» comprend les «cartes de crédit».

Article 52. — Substitution du montant souligné au montant de «deux cents dollars»; découle de la modification de l'article 483 proposée par l'article 114.

PEI



CHAPTER V-2

VENEREAL DISEASES PREVENTION ACT

1. In this Act
- | | Definitions |
|---|----------------------|
| (a) "Chief Health Officer" means the Chief Health Officer appointed under the <i>Public Health Act</i> , R.S.P.E.I. 1974, Cap. P-29; | Chief Health Officer |
| (b) "Minister" means the Minister of Health; | Minister |
| (c) "physician" means a legally qualified medical practitioner; | physician |
| (d) "place of detention" means a hospital, sanatorium, correctional institution, lock-up, training school, or any place designated as a place of detention by the Lieutenant Governor in Council; | place of detention |
| (e) "prescribed" means prescribed by the regulations; | prescribed |
| (f) "regulations" means the regulations made under this Act or the <i>Public Health Act</i> , R.S.P.E.I. 1974, Cap. P-29; | regulations |
| (g) "venereal disease" means syphilis, gonorrhoea, chancroid, granuloma inguinale or lymphogranuloma venereum. 1974(2nd),c.92,s.1. | venereal disease |
2. (1) Every person infected with venereal disease upon becoming aware or suspecting that he is so infected shall place himself forthwith under the care and treatment of a physician.
- | | Definitions |
|--|---|
| (2) Every person referred to in subsection (1) shall conduct himself in such a manner as not to expose other persons to the danger of infection, and shall take and continue treatment in a manner and to an extent considered to be adequate by the attending physician and the Minister. 1974(2nd),c.92,s.2. | Infected person to submit to treatment

Duty not to expose others to infection, treatment |
3. (1) It is the duty of
- | | Definitions |
|---|----------------------|
| (a) every physician; | Duty to report cases |
| (b) every superintendent or head of a hospital, sanatorium or laboratory; and | |
| (c) every person in medical charge of any correctional institution, lock-up, training school, school or college or other similar institution; | |

to report within twenty-four hours every case of venereal disease coming under his diagnosis, treatment, care or charge for the first time to the Chief Health Officer.

Method of reporting

(2) Every person required to report a case of venereal disease under subsection (1) shall make the report in writing, by telephone, or in person to the Chief Health Officer. 1974(2nd),c.92,s.3.

Action of Chief Health Officer on reasonable belief

4. (1) Where the Chief Health Officer has reasonable grounds for believing that a person is or may be infected with venereal disease or has been exposed to infection, the Chief Health Officer may give notice in writing in the prescribed form to such person directing him to submit to an examination by a physician designated by or satisfactory to the Chief Health Officer, and to procure and produce to the Chief Health Officer within the time specified in the notice, a report or certificate of the physician that such person is or is not infected with venereal disease.

Offence

(2) Every person who without reasonable excuse, the proof of which is upon him, fails to comply with a direction made under subsection (1) is guilty of an offence and liable to imprisonment for a term of not less than seven days and not more than twelve months.

Powers of Chief Health Officer on report

(3) If by the report or certificate mentioned in subsection (1) it appears that the person so notified is infected with venereal disease, the Chief Health Officer may

(a) deliver to such person directions in the prescribed form as to the course of conduct to be pursued and may require such person to produce from time to time evidence satisfactory to the Chief Health Officer that he is undergoing adequate medical treatment and is in other respects carrying out such directions, and where such person fails to comply with the course of conduct prescribed for him or to produce the evidence required, the Chief Health Officer may exercise all the powers vested in him by clause (b) or may proceed under section 6; or

(b) with the approval of the Minister, order in writing that such person be removed and detained in a place of detention for the prescribed treatment until such time as the Chief Health Officer is satisfied that an adequate degree of treatment has been attained.

Duties of peace officer on order of Chief Health Officer

(4) Where the Chief Health Officer makes an order under clause (3)(b) he shall deliver the order to a peace officer who shall thereupon take the person named in the order into his custody and remove him to the place of detention named in the order, and the person for the time being in charge of the place of detention, upon receiving the order, shall receive such person and shall detain him until he is authorized by the Chief Health Officer to release him.

Where person certified within one year

(5) The Chief Health Officer may adopt the procedure or do any of the acts referred to in subsection (3) with regard to any person

who has been examined by a physician at any time within one year previously and has been certified by such physician to be infected with syphilis.

(6) The Chief Health Officer may require a person who he believes may be infected with venereal disease to undergo more than one examination in order to determine the presence or absence of the infection. 1974(2nd),c.92,s.4.

More than one examination may be required

5. (1) Where

- (a) any person has been named under oath as a source or contact of venereal disease or is believed by the Chief Health Officer to be a source or contact of the venereal disease; and
- (b) in the opinion of the Chief Health Officer the clinical findings and history of such person indicate that such person is or may be infected with venereal disease;

Authority of Chief Health Officer

the Chief Health Officer may, whether or not laboratory findings indicate the presence of venereal disease, proceed in the manner prescribed in clauses 4(3)(a) and (b).

(2) For the purposes of subsection (1), the Chief Health Officer may administer an oath and take a statement under oath. 1974(2nd),c.92,s.5.

Chief Health Officer may take statement under oath

6. (1) The Chief Health Officer may make a complaint or lay an information in writing and under oath before a provincial judge charging that the circumstances set out in clause (5)(a) or (b) exist with regard to any person named in the complaint or information.

Information or complaint

(2) Upon receiving a complaint or information, the provincial judge shall hear and consider the allegations of the complainant, and if he considers it desirable or necessary, the evidence of any witnesses, and if he is of the opinion that a case for so doing is made out, he shall issue a summons directed to the person complained of requiring the person complained of to appear before him at a time and place named therein.

Issue of summons

(3) Where a person to whom a summons is directed does not appear at the time and place named therein or where it appears that a summons cannot be served, a provincial judge may issue a warrant directing that the person named in the summons be brought before him.

Issue of warrant

(4) Where a person appears or is brought before a provincial judge under this section, the judge shall inquire into the truth of the matters charged in the complaint or information and for such person shall proceed in the summary manner set forth in Part XXIV of the *Criminal Code* of Canada, R.S.C. 1970, Chap. C-34 and has all such powers as may be necessary to enable him to exercise that jurisdiction.

Provincial judge's inquiry

Order for
detention

(5) Where a provincial judge finds that any person

(a) is infected with a venereal disease and is unwilling or unable to conduct himself in such a manner as not to expose other persons to the danger of infection; or

(b) is infected with a venereal disease and refuses or neglects to take or continue treatment as required by this Act and the regulations;

he shall order that such person be admitted to and detained in a place of detention for such period not exceeding one year as the provincial judge may consider necessary.

Laboratory
certificate *prima*
facie evidence

(6) In any inquiry under this section, a certificate as to the result of any test made, signed or purporting to be signed by the director of a laboratory approved by the Minister is *prima facie* evidence of the facts stated therein and of the authority of the person giving such certificate without any proof of appointment of signature.

Extension of
detention

(7) Any person detained under this section may, with the approval in writing of the Minister, be brought before a provincial judge at any time during the last thirty days of the period for which he is so detained, and if the judge finds that he is still infected with venereal disease and in need of further treatment, he may order that such person be further detained for a period not exceeding one year as the judge may consider necessary.

Discharge by
Minister

(8) Where the Minister is of the opinion that any person detained under this section is no longer infected with venereal disease or has received an adequate degree of treatment, he may direct the discharge of such person. 1974(2nd),c.92,s.6.

Examination by
physician in
charge of
institution

7. (1) Where any physician in medical charge of any correctional institution, lock-up or training school, has reason to believe that any person under his charge may be infected with venereal disease or has been exposed to infection with venereal disease, he may, and if he is directed by the Chief Health Officer, he shall cause such person to undergo such examination as may be necessary to ascertain whether or not he is infected with venereal disease or to ascertain the extent of venereal disease infection, and if the examination discloses that he is so infected, the physician shall report the facts to the Chief Health Officer who may thereupon exercise the powers vested to him by section 9.

Duty of
physician in
charge of
institution

(2) Where an examination has not been made under this section, every physician in medical charge of any correctional institution, lock-up or training school, shall report to the Chief Health Officer the name and place of confinement of any person under his charge whom he suspects or believes to be infected with venereal disease and the report shall be made within twenty-four hours after he suspects or believes such person to be so infected.

Duplicate report

(3) A copy or statement of every report made under this section shall be forwarded to the Minister and the Chief Health Officer by the physician making the report. 1974(2nd),c.92,s.7.

8. When the Chief Health Officer believes that any person under arrest or in custody, whether awaiting trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, bylaw or order made thereunder or serving the sentence of a court upon conviction of any such offence or contravention, has been or may be infected or has been exposed to infection with venereal disease, he may cause such person to undergo such examination as may be necessary in order to ascertain whether or not such person is infected with venereal disease, and may direct that such person shall remain in custody until the results of the examination are known. 1974(2nd),c.92,s.8.

Examination of
person in custody
or committed to
prison

9. Where any person under arrest or in custody, whether awaiting trial for any offence under, or contravention of, any statute of Canada or of the Legislature or any regulation, bylaw or order made thereunder or serving the sentence of a court upon conviction of any such offence, or contravention, is found to be infected with venereal disease, the Chief Health Officer may by order in writing direct that such person undergo treatment therefor and that such action be taken as the Chief Health Officer or the Minister may consider advisable for his isolation and the prevention of infection by him, and that he be detained in custody until cured or until he has received a degree of treatment considered adequate by the attending physician and the Minister, notwithstanding that he may be otherwise entitled to be released, and any order made under this section is sufficient warrant to the person to whom the order is addressed to carry out the terms thereof. 1974(2nd),c.92,s.9.

Treatment where
disease found to
exist

10. (1) Where a person who has been under treatment for venereal disease refuses or neglects to continue treatment in a manner and to a degree satisfactory to the attending physician and the Minister, the physician shall report to the Minister the name and address of such person together with such other information as may be required by the regulations.

Physician to
report person
refusing to
continue
treatment

(2) A person who fails to attend upon his physician within seven days of an appointment for treatment shall be presumed to have neglected to continue treatment and the attending physician shall report this failure in writing to the Minister and the Chief Health Officer within fourteen days of the appointment.

Failure to attend
within seven
days

(3) A physician who fails to report as required by this section is guilty of an offence and is liable to a fine of not less than one hundred dollars and not more than five hundred dollars, and in default of payment thereof to imprisonment for a term of not more than twelve months. 1974(2nd),c.92,s.10.

Offence

11. (1) No person other than a physician shall attend upon or prescribe for or supply or offer to supply any drug, medicine, appliance or treatment to or for a person suffering from venereal disease for the purpose of the alleviation or cure of such disease.

Supply of drugs,
etc., by
unqualified
persons
prohibited

Offence (2) Every person who contravenes subsection (1) is guilty of an offence and is liable to a fine of not less than one hundred dollars and not more than five hundred dollars and in default of immediate payment shall be imprisoned for a term of not more than twelve months.

Exception as to chemists (3) Subsection (1) does not apply to a registered pharmaceutical chemist who dispenses to a patient of a physician upon receipt of a written prescription signed by the physician or who sells to any person any patent, proprietary or other medicine, drug or appliance prescribed by a physician for the cure or alleviation of venereal disease, but no prescription shall be filled more than once except upon the written direction of the prescribing physician. 1974 (2nd), c.92, s.11.

Offences 12. (1) Every person who

- (a) willfully neglects or disobeys any order or direction given by the Chief Health Officer or the Minister or Deputy Minister under this Act or the regulations;
- (b) hinders, delays or obstructs any health officer, public health nurse, peace officer or other person acting in the performance of his duties under this Act;
- (c) publishes any proceedings taken under this Act or the regulations contrary to subsection (2);
- (d) willfully represents himself as bearing some other name other than his own or makes any false statements as to his ordinary place of residence during the course of his treatment for any venereal disease with the purpose of concealing his identity;
- (e) during the course of his treatment for any venereal disease changes his place of residence without giving due notice of the proposed change with his new address to the attending physician; or
- (f) fails to comply with this Act or the regulations;

is guilty of an offence and, where no other penalty is prescribed, is liable to a fine of not less than twenty-five dollars and not more than one hundred dollars and in default of immediate payment shall be imprisoned for a term of not more than three months.

Prosecutions (2) Part XXIV of the *Criminal Code* of Canada, R.S.C. 1970, Chap. C-34 is included herein as part of this Act and applies to prosecutions under this Act or the regulations but all proceedings for the recovery of penalties under this Act and proceedings authorized by section 6 shall be conducted *in camera* and no person shall publish or disclose any such proceedings except under the authority of this Act or the regulations.

Summons by personal service (3) Notwithstanding the provisions of subsection (2), service of any summons issued for a contravention of this Act may be effected by personal service. 1974(2nd), c.92, s.12.

13. (1) Every person who publicly or privately, verbally or in writing, directly or indirectly, states or intimates that any other person has been notified or examined or otherwise dealt with under this Act, whether such statement or intention is or is not true, is guilty of an offence, and in addition to any other penalty or liability, is liable to a fine of two hundred dollars and in default of immediate payment shall be imprisoned for a term of not more than six months.

Statements as to
existence of
disease

(2) Subsection (1) does not apply

Exception

- (a) to a communication or disclosure made in good faith,
 - (i) to the Minister, Deputy Minister of Health or Chief Health Officer,
 - (ii) to a health officer or public health nurse for their information in carrying out this Act,
 - (iii) to a physician,
 - (iv) in the course of consultation for treatment for venereal disease,
 - (v) to the superintendent or head of any place of detention;
- (b) to any evidence given in any judicial proceedings of facts relevant to the issue; or
- (c) to any communication authorized or required to be made by this Act or the regulations;

(3) Notwithstanding subsection (1), a physician may give information concerning the patient to other members of the patient's family for the protection of health. 1974(2nd),c.92,s.13.

Information to
family

14. Every person engaged in the administration of this Act shall preserve secrecy with regard to all matters that may come to his knowledge in the course of such employment and shall not communicate in such matter to any other person except in the performance of his duties under this Act or when instructed to do so by the Chief Health Officer or the Minister and in default he shall in addition to any other penalty forfeit his office or be dismissed from his employment. 1974(2nd),c.92,s.14.

Obligation to
observe secrecy

15. No person shall issue or make available to any person other than a physician or such persons as are engaged in the administration of this Act any laboratory report either in whole or in part of an examination made to determine the presence or absence of venereal disease. 1974(2nd),c.92,s.15.

Laboratory
reports

16. Every hospital receiving payment from the Province of Prince Edward Island shall make adequate provision for the reception, examination and treatment, upon such terms as may be prescribed, of such persons or classes of persons infected with venereal disease as may by this Act or the regulations be required or permitted to be treated at such hospital, and in case of default the Minister of Finance of Prince Edward Island may withhold from any hospital

Hospitals to
make provision
for treatment etc.

the whole or any part of any moneys that would otherwise be payable. 1974(2nd),c.92,s.16.

Places of
detention,
maintenance,
conduct

17. Where a person is admitted to a place of detention under this Act, whether the admission is voluntary or under the order of a provincial judge or the Chief Health Officer

- (a) subject to the regulations, the provisions of law relating to the liability for and payment of maintenance of patients, inmates or pupils in such place of detention apply; and
- (b) such person is subject to all rules, regulations, and provisions of law governing the conduct of patients, inmates or pupils of such place of detention. 1974(2nd),c.92,s.17.

Consent of
persons 16 or
over to treatment

18. (1) The consent of any person of the age of sixteen years or over to being examined or treated or both for venereal disease shall be deemed to be sufficient consent for such purposes and where such consent is given no action or other proceeding lies against a physician for acting upon such consent.

Under sixteen
years

(2) No action or other proceeding lies against a physician for acting upon a consent given by a person under sixteen years of age to be examined or treated or both for venereal disease if the physician had no reason to believe that the person giving the consent was under sixteen years of age. 1974(2nd),c.92,s.18.

Where person
infected is under
16 years of age

19. Where any person infected or believed to be infected with venereal disease is a child under the age of sixteen years, all notices, directions or orders required or authorized by this Act or by the regulations to be given in respect of the child shall be given to the father or mother or to the person having custody of the child for the time being and it is the duty of the father, mother or other person to see that the child complies in every respect with every such notice, order or direction and in default thereof the father, mother or other person, as the case may be, is liable to the penalties provided by this Act or the regulations for non-compliance with any such notice, direction or order unless on any prosecution in that behalf it is proven to the satisfaction of the court that the father, mother or other person did everything in his power to cause the child to comply therewith. 1974(2nd),c.92,s.19.

Regulations

20. (1) The Lieutenant Governor in Council may make regulations

- (a) prescribing the method and extent of the examination of any person for the purpose of ascertaining whether or not such person is infected with venereal disease or the extent of the infection;
- (b) prescribing the course of conduct to be pursued by any person infected with venereal disease in order to effect a cure and to prevent the infection of other persons;
- (c) prescribing the hospitals that shall furnish treatment to persons or any classes or persons infected with venereal disease;

- (d) prescribing rules for the treatment of persons infected with venereal disease in hospitals, places of detention and other places;
- (e) for preventing the spread of infection from persons suffering from venereal disease;
- (f) for distributing to physicians and hospitals information as to the treatment, diet and care of persons infected with venereal disease and requiring physicians and hospitals to distribute the information to such persons;
- (g) providing for the approval by the Minister of methods and remedies for the treatment, alleviation and cure of venereal diseases;
- (h) providing for the display of notices and placards dealing with venereal disease, its cause, manifestation, treatment and cure;
- (i) prescribing the forms of notices, certificates and reports required or authorized to be given or issued under this Act;
- (j) requiring every physician to furnish reports with respect to the condition and treatment of persons infected with venereal disease who are or who have been under his diagnosis, treatment, care or charge;
- (k) prescribing the procedure to be followed and the evidence required in case of an appeal to the Minister from any action or decision under this Act;
- (l) approving patent, proprietary or other medicines, drugs or appliances for the cure or alleviation of venereal disease;
- (m) prescribing the mode of sending or giving any notice, report or direction required or permitted to be sent or given by this Act or the regulations;
- (n) generally for the better carrying out of this Act, and for the prevention, treatment and cure of venereal disease.

(2) The Minister may, out of any moneys appropriated by the Legislature for the purposes of this Act, provide for the payment of the expenses incurred in carrying out this Act and the regulations including the manufacture and free distribution to physicians of any drug, medicine, appliance or instrument that the Minister may consider useful or necessary for the alleviation, treatment or cure of venereal disease or the prevention of infection therewith. 1974(2nd),c.92,s.20.

Expenses of free distribution

21. (1) Every person who considers himself aggrieved by any action or decision of the Chief Health Officer under this Act may appeal therefrom to the Minister by giving such notice in writing to the Minister and to the Chief Health Officer.

Appeal to Minister

(2) The Minister may require the appellant to furnish such information and evidence and to submit to such examination as may be prescribed or as the Minister may consider necessary to determine the matter in dispute.

Evidence on appeal

Decision final	(3) The decision of the Minister is final. 1974(2nd),c.92,s.21.
Right of entry	22. The Chief Health Officer or a physician or public health nurse designated by him in writing for the purpose may, with a warrant issued by a provincial judge, enter in and upon any house or premises for the purpose of making inquiry and examination with respect to the state of the health of any person therein and may cause any person found therein who is infected with any venereal disease to be removed to a place of detention or may give such direction as may prevent other persons in the same house or premises from being infected. 1974(2nd),c.92,s.22.
Powers of Deputy Minister	23. The Deputy Minister of Health and any officer of the department designated by the Minister are health officers within the meaning of this Act. 1974(2nd),c.92,s.23.
Delegation of powers	24. The Minister may delegate to the Deputy Minister of Health or any other officer of the Department of Health any of the powers vested in him under this Act or the regulations. 1974(2nd),c.92,s.24.
Administration of Act not to interfere with course of justice	25. The administration of this Act and the regulations shall not interfere with the course of justice in the case of any person under arrest or in custody previous to trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, bylaw or order made thereunder, but where it is necessary for the purpose of any examination authorized or required by this Act, such person may be held in custody until the results of the examination are known. 1974(2nd),c.92,s.25.

©
QUEEN'S PRINTER FOR PRINCE EDWARD ISLAND
CHARLOTTETOWN, 1974

Subsection 34(2) is amended by the deletion of the words "Public Works and Highways" and the substitution therefor of the words "Highways and Public Works".

Rural Community Fire Companies Act, R.S.P.E.I. 1974, Cap. R-16

Clause 1(b) is amended by the deletion of the words "Department of Community Services" and substitution therefor of the words "Department of Community Affairs".

Clause 1(c) is amended by the deletion of the words "Minister of Community Services" and the substitution therefor of the words "Minister of Community Affairs".

Section 3 is amended by the deletion of the words "Provincial Secretary" and the substitution therefor of the words "Director of Corporations".

Securities Act, R.S.P.E.I. 1974, Cap. S-4

Sections 1(c)(vi), 2(2), 3(1), (2), (4) and (5), 4(3), 5(2) and (3), 6(1), (2) and (3), 7(1), (2) and (3), 16(1), (2), (3) and (4), 17, 18(1), (2) and (3), 19(1) and (3), 20, 21, 22, 23, 24(2) and (3), 25, 27(4) and 28 are amended by the deletion of the words "Provincial Secretary" wherever they appear and the substitution therefor in each case of the words "Director of Corporations".

Summary Trespass Act, R.S.P.E.I. 1974, Cap. S-11

Clause 1(c) is amended by the deletion of the words "Minister of Industry and Commerce" and the substitution therefor of the words "Minister of Tourism, Industry and Energy".

Venereal Diseases Prevention Act, R.S.P.E.I., 1974, Cap. V-2

Clause 1(b) is amended by the deletion of the words "Minister of Health" and the substitution therefor of the words "Minister of Health and Social Services".

Section 24 is amended by the deletion of the words "Department of Health" and the substitution therefor of the words "Department of Health and Social Services".

Village Service Act, R.S.P.E.I. 1974, Cap. V-5

Subsection 3(3) is amended by the deletion of the words "Minister of Municipal Affairs" and the substitution therefor of the words "Minister of Community Affairs".

Subsections 41(4) and (5) are amended by the deletion of the words "Department of Public Works and Highways" and "Minister of Public Works and Highways" and the substitution therefor of the words "Department of Highways and Public Works" and "Minister of Highways and Public Works" respectively.

Vital Statistics Act, R.S.P.E.I. 1974, Cap. V-6

Subsection 26(1) is amended by the deletion of the words "Department of Health" and the substitution therefor of the words "Department of Health and Social Services".

Alberta

VENEREAL DISEASES PREVENTION ACT

CHAPTER V-2

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Alberta, enacts as follows:

Definitions

1 In this Act,

- (a) "clinical examination" means an examination for venereal disease consisting of a physical examination, the taking of samples or specimens from the body on the same occasion as the physical examination and the testing of the samples or specimens at the place where the samples or specimens were taken;
- (b) "Director" means the Director of the Division;
- (c) "Division" means the Division of Social Hygiene of the Department of Social Services and Community Health;
- (d) "infected" means having a venereal disease in a communicable stage;
- (e) "jail physician" means a physician in attendance in his professional capacity at a correctional institution, lock-up, reformatory or similar place;
- (f) "laboratory tests" means tests of samples or specimens from the body made in a laboratory at a place other than where the samples or specimens were taken;
- (g) "Minister" means the Minister of Social Services and Community Health;
- (h) "place of detention" means a hospital, sanatorium, correctional institution, lock-up, reformatory, or any place designated as a place of detention by the Lieutenant Governor in Council;
- (i) "provincial clinic" means a venereal disease clinic operated by the Division;
- (j) "venereal disease" means syphilis, gonorrhoea, chancroid, granuloma inguinale or lymphopathia venereum.

RSA 1970 c382 s2;1971 c25 s19(1);1975(2) c12 ss8,9

Duties of Infected Persons

Duty to take
treatment

2 Every person who knows or suspects or has reason to believe that he is or may be infected with venereal disease

(a) shall immediately consult a physician or attend at a provincial clinic to determine whether he is infected or not, and

(b) if he is found to be infected, shall submit to the treatment that is directed by a physician or at a provincial clinic until he is no longer infected with venereal disease in the opinion of the physician consulted or the physician in charge of a provincial clinic.

RSA 1970 c382 s3

Change of address
or physician

3 Every person who is required by section 2 to submit to treatment for venereal disease

(a) shall inform the physician consulted or the provincial clinic, as the case may be, of any change of his address occurring during the period of treatment, or

(b) if he is under treatment by a physician and wishes to discontinue treatment under that physician, shall immediately consult and submit to treatment by another physician or at a provincial clinic.

RSA 1970 c382 s4

Duties of Physicians and Others

Duty re reports

4(1) It is the duty of

(a) every physician,

(b) every superintendent or head of a hospital or sanatorium, and

(c) every person in charge of medical services in a correctional institution, lock-up or reformatory or similar place or in an educational institution,

to report to the Director every case of infection with venereal disease coming under his diagnosis, treatment, care or charge for the first time.

(2) The report shall be completed and forwarded to the Director within 48 hours after the first diagnosis, treatment or knowledge by or of the physician, superintendent, head or other person.

RSA 1970 c382 s5

Report of
laboratory tests

5 The person in charge of a laboratory shall report to the Director

(a) all positive and negative results of tests for syphilis made in the laboratory, and

(b) all positive results of tests for gonorrhoea made in the laboratory,

within 48 hours of the time the results are determined.

RSA 1970 c382 s6

Directions to
patient

6 Every physician who examines or treats a person for or in respect of venereal disease shall instruct him in measures for preventing the spread of the disease and inform him of the necessity for regular treatment until cured.

RSA 1970 c382 s7

Report re
delinquent patient

7(1) If an infected person under treatment for venereal disease by a physician refuses or neglects to continue his treatment in a manner and to a degree satisfactory to the physician, the physician shall forward a report to that effect to the Director unless he is sooner notified that the infected person is under treatment at a provincial clinic.

(2) A person who fails to attend on his physician within 7 days of an appointment for treatment for venereal disease shall be presumed to have neglected to continue his treatment and in that case the physician shall forward the report to the Director within 14 days of the appointment.

RSA 1970 c382 s8

Notice to Attend for Examination and Treatment

Notice to attend

8(1) When the Director has reasonable grounds for believing that a person is infected with venereal disease by virtue of

(a) a report forwarded to him pursuant to section 4, 5 or 7,

(b) the refusal or neglect of that person to continue treatment at a provincial clinic,

(c) that person being named in a statutory declaration as a probable source or contact of venereal disease, or

(d) any other proof or information in the possession of the Director,

the Director or a person authorized by the Director to do so may serve a notice on that person requiring him to attend at the provincial clinic nearest his residence or at the office of a named physician for examination for venereal disease and, if he is found to be infected, for treatment of the disease.

(2) A notice under subsection (1)

- (a) shall specify the time at or within which the person is to attend, and
 - (b) may require more than one attendance for examination.
- (3) When the notice requires attendance at the office of a named physician, the Director shall send a copy of it to that physician with directions to
- (a) conduct a clinical examination of the person suspected of being infected,
 - (b) send any samples or specimens taken from the person's body to a laboratory for testing, and
 - (c) forward a certificate to the Director within a prescribed time stating whether or not, on the basis of the clinical examination and the laboratory tests, if any, the person examined is infected with venereal disease.
- (4) When a person notified pursuant to subsection (1) is found to be infected by virtue of the certificate of a physician in charge of a provincial clinic or the named physician, as the case may be, or by virtue of the certificate of the person in charge of the laboratory where the tests were made, the Director or a physician in charge of a provincial clinic may by notice give directions to that person as to the course of conduct to be pursued by him in undergoing treatment for venereal disease.
- (5) When it is intended to name a physician in a notice under this section, the Director shall consult that physician before doing so.

RSA 1970 c382 s9

Persons Required to Undergo Treatment

Detention for
treatment

- 9(1) The Director or an officer of the Division authorized by the Director to do so may lay an information before a provincial judge stating that he has reason to believe that the person named therein is infected with venereal disease on any of the following grounds:
- (a) that the person has failed to comply with a notice served on him under section 8(1) or (4);
 - (b) that the person has been found to be infected on the basis of a clinical examination or laboratory tests and has refused or neglected to submit to treatment or to continue treatment;
 - (c) that the person has been named in a statutory declaration as a probable source or contact of venereal disease;
 - (d) that in the opinion of the Director the clinical findings and history of the person indicate that he is or may be infected with venereal disease.

(2) On receiving the information the provincial judge shall hear and consider the allegations of the informant and if he considers it necessary or desirable the evidence of any witness, and if he is of the opinion that a case for so doing has been made out he shall issue his warrant to take the person named therein into custody and cause him to be taken to a place of detention and detained there

(a) for a clinical examination to determine whether he has venereal disease, and

(b) if he is found to be infected, for treatment for venereal disease until he is no longer infected.

(3) A person detained under subsection (2) shall be given a clinical examination forthwith on being so detained.

(4) The attending physician, immediately on completion of the clinical examination, shall issue and forward to a provincial judge a certificate stating that the person named therein either

(a) is infected with venereal disease, in which case he shall be detained for treatment until he is no longer infected,

(b) is not infected with venereal disease, in which case the provincial judge shall order his immediate release, or

(c) is not infected with venereal disease on the basis of the clinical examination only and without the result of laboratory tests being determined, in which case the provincial judge shall order his immediate release.

(5) When a provincial judge is in receipt of a certificate of a physician stating that a person detained for treatment under subsection (4)(a) is no longer infected with venereal disease, the provincial judge shall forthwith order the immediate release of that person.

RSA 1970 c382 s10

Warrant after
laboratory tests

10(1) If a person is released pursuant to section 9(4)(c) and the laboratory tests subsequently show that the person is infected, a further information may be laid under section 9(1)(b) and if the provincial judge issues his warrant,

(a) no clinical examination is necessary, and

(b) on being detained in a place of detention, the person is deemed to be detained pursuant to section 9(4)(a).

(2) In any case to which subsection (1) refers, the provincial judge may refuse the information if the application is made later than 7 days after the results of the laboratory tests are known.

RSA 1970 c382 s11

Physician's
certificate as
evidence

11 In proceedings under section 9, the certificate of a physician stating that the person named therein is infected with venereal disease

is and shall be admitted in evidence as prima facie proof of that fact and that the person making it is a physician, without the necessity of proving the qualifications or signature of the physician making it.

RSA 1970 c382 s12(1)

Name of contact

12 When the ground or one of the grounds on which an information is laid under section 9 is that the person against whom the proceedings are taken has been named in a statutory declaration as a probable source or contact of venereal disease

(a) it is not necessary that the declaration be an exhibit to the information, and

(b) neither the person against whom the proceedings are taken, his counsel or agent is entitled in those proceedings, or in any proceedings in the Court of Queen's Bench for an order in the nature of a prerogative writ arising out of proceedings under section 9, to inspect the declaration or ascertain the name of the declarant,

but the judge may request that the declaration be produced to him for examination as to its validity or sufficiency.

RSA 1970 c382 s12(2);1978 c51 s28

Examination of
persons under
arrest

13(1) When a person is under arrest or in custody and charged with a criminal offence, a jail physician may cause him to undergo a clinical examination to determine whether or not he is infected with venereal disease

(a) if that person is charged under any of the following provisions of the *Criminal Code* (Canada):

(i) paragraph 175(1)(d) by reason of living wholly or in part on the avails of prostitution;

(ii) subsection 193(1);

(iii) paragraph 193(2)(a) or (b);

(iv) subsection 195(1),

or

(b) in any other case, if the Director or the jail physician has reason to believe that the person is or may have been exposed to infection with venereal disease.

and may order that the person remain in custody until the clinical examination is completed.

(2) When a physician certifies that the person examined is infected, the infected person shall undergo medical treatment for venereal disease but only while he is in custody and if he is not otherwise entitled to be released.

RSA 1970 c382 c13;1978 c13 s29

Examination of
convicted persons

14(1) When a person is in custody serving a sentence imposed on a conviction, a jail physician may cause him to undergo a clinical examination to determine whether or not he is infected with venereal disease and may order that the person remain in custody until the clinical examination is completed.

(2) When a physician certifies that a person in custody serving a sentence imposed on a conviction is infected

(a) the infected person shall undergo medical treatment for the disease and any action shall be taken that the jail physician considers advisable for his isolation and prevention of infection by him, and

(b) notwithstanding that he may otherwise be entitled to be released, he shall be detained in custody for treatment until he is no longer infected.

(3) When a physician is of the opinion that a person detained for treatment under this section is no longer infected with venereal disease, the physician shall forthwith issue a certificate to that effect and cause it to be delivered immediately to the jailer, director, superintendent, constable or officer having the care and custody of the person so detained.

(4) A certificate issued under subsection (3) is sufficient warrant and authority to the jailer, director, superintendent, constable or officer having the care and custody of that person to release him from custody if he is otherwise entitled to be released.

1965 c99 s14

Physician's
certificates, orders

15(1) A certificate made under section 13(2) or 14(2) shall be based either on the clinical examination or on the results of laboratory tests.

(2) An order of a jail physician or a certificate of a physician under section 13 or 14 is sufficient warrant to the jailer, director, superintendent, constable or officer having the care and custody of the person so charged or convicted to detain that person until the clinical examination is completed and, in the case of a convicted person found to be infected, to carry out the provisions of section 14(2).

(3) An infected person required to undergo medical treatment under section 13 or 14 shall comply with all directions given by a jail physician as to treatment and every jailer, director, superintendent, constable and officer having the care and custody of an infected person shall see that the directions of the jail physician are carried out.

1965 c99 s15

Release from
detention

16(1) In this section "person detained for treatment" means a per-

son detained in custody for treatment for venereal disease pursuant to

- (a) section 9(4), or
 - (b) section 14(2) and who is otherwise entitled to be released.
- (2) Notwithstanding anything in section 9 or 14, a provincial judge may, on application of which the Director has been given notice sufficient in the opinion of the provincial judge, order the release of a person detained for treatment on the conditions that the person
- (a) attend for treatment at a specified provincial clinic or on a physician named in the order, and
 - (b) comply with the directions for treatment prescribed by the physician in charge of the provincial clinic or the named physician, as the case may be, until he is no longer infected with venereal disease.
- (3) The Director or an officer of the Division authorized by the Director to do so may lay an information before a provincial judge stating that he has reason to believe that the person released pursuant to an order made under subsection (2) has failed to comply with a condition of the order.
- (4) On receiving the information the provincial judge shall hear and consider the allegations of the informant and if he considers it necessary or desirable the evidence of any witness, and if he is of the opinion that a case for so doing has been made out, he shall issue his warrant to take the person named therein into custody and cause him to be taken to a place of detention and detained there for treatment until he is no longer infected with venereal disease.
- (5) When a provincial judge is in receipt of a certificate of a physician that a person detained pursuant to subsection (4) is no longer infected with venereal disease, the provincial judge shall forthwith order the immediate release of that person.
- (6) A person detained under subsection (4) is not precluded from making a further application for an order under subsection (2).

1965 c99 s16

General

Regulations

17 The Lieutenant Governor in Council may make regulations

- (a) prescribing a schedule of fees payable to physicians for services performed in reporting, diagnosing or treating cases of venereal disease and for drugs, medicines or appliances supplied to their patients;
- (b) authorizing the Minister to pay fees to physicians in ac-

cordance with the schedule prescribed under clause (a) and prescribing the terms and conditions on which the fees may be paid;

(c) prescribing the forms of informations, certificates, warrants and orders to be used for the purpose of this Act;

(d) generally, for the carrying out of the provisions of this Act and for the prevention, treatment and cure of venereal diseases.

1965 c99 s17

Powers of Minister **18** The Minister may

(a) establish and maintain one or more venereal disease clinics in Alberta to be operated by the Division,

(b) subject to the *Public Service Act*, appoint physicians to be in charge of or to conduct examinations or to carry out or supervise treatment of persons for venereal disease at provincial clinics, and

(c) provide for the free distribution to hospitals and other institutions of any drug, medicine or thing for the diagnosis, treatment or cure of venereal disease or the prevention of infection therefrom.

1965 c99 s18

Powers of Director **19** The Director may

(a) prescribe the form of reports and notices required or authorized to be given to or by the Director under this Act,

(b) appoint or engage physicians to conduct clinical examinations or perform or supervise the treatment for venereal disease of persons to whom notices are given under section 8, and persons released pursuant to section 16,

(c) provide for the distribution to physicians and hospitals of information as to the treatment and care of persons suffering from venereal disease, and

(d) provide for public advertising and placarding of information relating to the treatment and cure of venereal disease and the places where proper treatment can be obtained.

1965 c99 s19

Hospitals to
provide
accommodation

20(1) Every approved hospital within the meaning of the *Hospitals Act* shall provide accommodation satisfactory to the Director for those persons infected or suspected of being infected with venereal disease that are assigned to it.

(2) The treatment for those persons shall be carried out under the directions given by the Director.

(3) The Lieutenant Governor in Council may designate any hospital

or other public institution, any portion of any hospital or institution under its jurisdiction or any house or building as a place of detention for the purposes of this Act.

1965 c99 s20

Protection against
action

21 No action, prosecution or other proceeding lies against any person by reason of the making by him of any certificate, report, notice, information, oral or written statement, statutory declaration, communication or record indicating directly or indirectly that any other person is or was or may be or may have been infected with venereal disease, if it is made in good faith and in the course of the administration of this Act or the regulations.

1965 c99 s21

Administration of
Act

22 This Act shall be administered so as not to interfere with the course of justice in the case of a person under arrest or in custody prior to trial for a criminal offence except to the extent that it is necessary, for the purpose of this Act, to detain that person in custody until the clinical examination is completed.

1965 c99 s22

When proceedings
in private

23(1) All proceedings

(a) under sections 9 and 16, or

(b) pertaining to applications to the Court of Queen's Bench for an order in the nature of a prerogative writ arising out of any proceeding under section 9 or 16,

shall be conducted in private.

(2) In any proceedings

(a) pertaining to a prosecution for an offence against this Act or an appeal therefrom, or

(b) pertaining to applications to the Court of Queen's Bench for an order in the nature of a prerogative writ arising out of any prosecution for an offence against this Act, or an appeal from the granting or refusing of the order,

the court shall order that the whole or any part of the proceedings shall be held in private when it is shown to the court that the evidence to be given in the proceedings or part thereof will or is likely to indicate any person as being or having been infected with venereal disease and to reveal his identity and that the giving of that evidence in public will cause unnecessary hardship to the person in the circumstances.

(3) All records, transcripts and documents pertaining to any proceedings referred to in subsections (1) and (2) are confidential and shall not be made accessible for public inspection.

(4) No person shall make or publish a report or transcript of any

proceedings referred to in subsection (1) or (2) unless the report or transcript forms part of the reasons for judgment given by a judge, is contained in a publication devoted primarily to the reporting of judicial decisions and does not disclose the name of any person who in those proceedings was alleged or shown to be or to have been infected with venereal disease.

RSA 1970 c382 s23;1978 c51 s28

Secrecy of
information

24(1) In the public interest, any file, record, document or paper kept by any person in any place

- (a) that indicates in any way that any person is or was infected or is or was suspected of or alleged to be infected, and
- (b) that came into existence through any thing done under or pursuant to this Act or its predecessors,

shall not, without the written consent of the Minister, be disclosed to any person except to a person to whom its disclosure is or was necessary in the course of the administration of this Act or its predecessors.

(2) A person who is or has been employed or engaged in the administration of this Act shall not disclose or be compelled to disclose any information obtained by him in the course of the performance of his duties under this Act

- (a) except at a trial of an accused for an offence against this Act or in proceedings under section 9, and
- (b) in any other case, except on the written consent of the Minister.

1965 c99 s24

Service of notice

25 Any notice permitted or required to be given under this Act may be given personally or by registered mail addressed to the addressee's last known address.

1965 c99 s25

Offences and Penalties

Treatment by
unqualified person

26(1) No person other than a physician shall attend on or prescribe, recommend, supply or offer to supply to or for any person any drug, medicine, treatment or thing for the alleviation or cure of venereal disease.

(2) Subsection (1) does not apply to

- (a) a registered pharmaceutical chemist who dispenses a physician's prescription, or
- (b) a registered nurse who acts on the instructions of or under

the supervision of a physician.

1965 c99 s26

Offences

27 A person is guilty of an offence who

(a) fails to comply with section 2, 3, 4, 5 or 7, or a notice or direction given to him under section 8,

(b) without justification or excuse, publishes, discloses, exhibits or makes accessible to the public any report or document relating to proceedings required by this Act to be conducted in private or discloses any file, record, document, paper or information in contravention of section 24,

(c) contravenes section 26, or

(d) wilfully represents himself as bearing some other name than his own or makes any false statement as to his ordinary place of residence during the course of his treatment for venereal disease with the purpose of concealing his identity.

1965 c99 s27

Penalty

28 A person who is guilty of an offence under this Act is liable to a fine of not more than \$200 and in default of payment to imprisonment for a term of not more than 90 days.

1965 c99 s28

Prosecution

29 No prosecution shall be taken against any person for an offence under this Act except with the consent of the Minister.

1965 c99 s29

Ontario

CHAPTER 521

Venereal Diseases Prevention Act

1. In this Act,

Interpre-
tation

- (a) "medical officer of health" means a medical officer of health appointed under the *Public Health Act*; R.S.O. 1980, c. 409
- (b) "Minister" means the Minister of Health;
- (c) "place of detention" means a hospital, sanatorium, correctional institution, lock-up, Ontario training school, or any place designated as a place of detention by the Lieutenant Governor in Council but does not include an isolation hospital for the care of communicable diseases, other than venereal disease, as defined by the *Public Health Act*;
- (d) "physician" means a legally qualified medical practitioner;
- (e) "prescribed" means prescribed by the regulations;
- (f) "regulations" means the regulations made under this Act or the *Public Health Act*;
- (g) "venereal disease" means syphilis, gonorrhoea, chancroid, granuloma inguinale or lymphogranuloma venereum. R.S.O. 1970, c. 479, s. 1; 1971, c. 33, s. 1.

2.—(1) Every person infected with venereal disease upon becoming aware or suspecting that he is so infected shall place himself forthwith under the care and treatment of a physician, and if unable to obtain such care or treatment he shall apply to the medical officer of health for the place in which he is ordinarily or temporarily resident.

Infected
person to
submit to
treatment

(2) Every such person shall conduct himself in such a manner as not to expose other persons to the danger of infection, and shall take and continue treatment in a manner and to an extent considered to be adequate by the attending physician and the Minister. R.S.O. 1970, c. 479, s. 2.

Idem

Duty to
report

3.—(1) It is the duty of,

- (a) every physician;
- (b) every superintendent or head of a hospital, sanatorium or laboratory; and
- (c) every person in medical charge of any correctional institution, lock-up, training school, school or college or other similar institution,

to report within twenty-four hours every case of venereal disease coming under his diagnosis, treatment, care or charge for the first time to the medical officer of health in the locality in which such diagnosis, treatment, care or charge is made.

Method of
reporting

(2) Every person required to report a case of venereal disease under subsection (1) shall make such report in writing, by telephone, or in person to the medical officer of health.

Report to
Minister

(3) The report referred to in subsection (2) shall within one week of being received by the medical officer of health be forwarded in the prescribed form to the Minister. 1971, c. 33, s. 2.

Action of
m.o.h. on
reasonable
belief

4.—(1) Where a medical officer of health has reasonable grounds for believing that a person within the municipality is or may be infected with venereal disease or has been exposed to infection, the medical officer of health may give notice in writing in the prescribed form to such person directing him to submit to an examination by a physician designated by or satisfactory to the medical officer of health, and to procure and produce to the medical officer of health within the time specified in the notice, a report or certificate of the physician that such person is or is not infected with venereal disease.

Offence

(2) Every person who without reasonable excuse, the proof of which is upon him, fails to comply with a direction made under subsection (1) is guilty of an offence and liable to imprisonment for a term of not less than seven days and not more than twelve months.

Powers of
m.o.h. on
report

(3) If by the report or certificate mentioned in subsection (1) it appears that the person so notified is infected with venereal disease, the medical officer of health may,

- (a) deliver to such person directions in the prescribed form as to the course of conduct to be pursued

and may require such person to produce from time to time evidence satisfactory to the medical officer of health that he is undergoing adequate medical treatment and is in other respects carrying out such directions, and where such person fails to comply with the course of conduct prescribed for him or to produce the evidence required, the medical officer of health may exercise all the powers vested in him by clause (b) or may proceed under section 6; or

- (b) with the approval of the Minister, order in writing that such person be removed and detained in a place of detention for the prescribed treatment until such time as the medical officer of health is satisfied that an adequate degree of treatment has been attained.

(4) Where a medical officer of health makes an order under clause (3) (b), he shall deliver the order to a peace officer who shall thereupon take the person named in the order into his custody and remove him to the place of detention named in the order, and the person for the time being in charge of the place of detention, upon receiving the order, shall receive such person and shall detain him until he is authorized by the medical officer of health to release him.

Duties of
peace officer
on order
of m.o.h.

(5) A medical officer of health may adopt the procedure or do any of the acts referred to in subsection (3) with regard to any person who has been examined by a physician at any time within one year previously and has been certified by such physician to be infected with syphilis.

Where
person
certified
within
one year

(6) A medical officer of health may require a person whom he believes may be infected with venereal disease to undergo more than one examination in order to determine the presence or absence of such infection. R.S.O. 1970, c. 479, s. 4.

More
than one
examination
may be
required

5.—(1) Where,

Authority of
M.O.H.

- (a) any person has been named under oath as a source or contact of venereal disease or is believed by the medical officer of health to be a source or contact of such venereal disease; and
- (b) in the opinion of the medical officer of health the clinical findings and history of such person

indicate that such person is or may be infected with venereal disease,

the medical officer of health may, whether or not laboratory findings indicate the presence of venereal disease, proceed in the manner prescribed in clauses 4 (3) (a) and (b). 1971, c. 33, s. 3.

Medical officer of health may take statement under oath

(2) For the purposes of subsection (1), a medical officer of health may administer an oath and take a statement under oath. R.S.O. 1970, c. 479, s. 5 (2).

Information or complaint

6.—(1) Any medical officer of health may make a complaint or lay an information in writing and under oath before a justice of the peace charging that the circumstances set out in clause (5) (a) or (b) exist with regard to any person named in such complaint or information.

Issue of summons

(2) Upon receiving any such complaint or information, the justice of the peace shall hear and consider the allegations of the complainant, and if he considers it desirable or necessary the evidence of any witness or witnesses, and if he is of the opinion that a case for so doing is made out he shall issue a summons directed to the person complained of requiring him to appear before a provincial judge at a time and place named therein.

Issue of warrant

(3) Where a person to whom a summons is directed does not appear at the time and place named therein or where it appears that a summons cannot be served, a provincial judge may issue a warrant directing that the person named in the summons be brought before him.

Provincial judge's inquiry

(4) Where a person appears or is brought before a provincial judge under this section, the judge shall inquire into the truth of the matters charged in the complaint or information and for such purpose shall proceed in the manner prescribed by the *Provincial Offences Act* and has the powers of a provincial judge holding a hearing under that Act.

R.S.O. 1980, c. 400

Order for detention

(5) Where a provincial judge finds that any person,

(a) is infected with a venereal disease and is unwilling or unable to conduct himself in such a manner as not to expose other persons to the danger of infection; or

- (b) is infected with a venereal disease and refuses or neglects to take or continue treatment as required by this Act and the regulations,

he shall order that such person be admitted to and detained in a place of detention for such period not exceeding one year as the provincial judge may consider necessary.

(6) In any inquiry under this section, a certificate as to the result of any test made, signed or purporting to be signed by the director of a laboratory approved by the Minister is *prima facie* evidence of the facts stated therein and of the authority of the person giving such certificate without any proof of appointment or signature.

Laboratory
certificate
prima facie
evidence

(7) Any person detained under this section may, with the approval in writing of the Minister, be brought before a provincial judge at any time during the last thirty days of the period for which he is so detained, and if the judge finds that he is still infected with venereal disease and in need of further treatment, he may order that such person be further detained for such period not exceeding one year as the judge may consider necessary.

Extension
of detention

(8) Where the Minister is of the opinion that any person detained under this section is no longer infected with venereal disease or has received an adequate degree of treatment, he may direct the discharge of such person.

Discharge by
Minister

R.S.O. 1970, c. 479, s. 6.

7.—(1) Where any physician in medical charge of any correctional institution, lock-up or training school, has reason to believe that any person under his charge may be infected with venereal disease or has been exposed to infection with venereal disease, he may, and if he is directed by the medical officer of health, he shall cause such person to undergo such examination as may be necessary to ascertain whether or not he is infected with venereal disease or to ascertain the extent of venereal disease infection and if the examination discloses that he is so infected the physician shall report the facts to the medical officer of health who may thereupon exercise the powers vested in him by section 9.

Examination
by physician
in charge of
institution

(2) Where an examination has not been made under this section, every physician in medical charge of any correctional institution, lock-up, or training school, shall report to the medical officer of health the name and place of confinement of any person under his charge whom he suspects or believes to be infected with venereal disease

Duty of
physician
in charge of
institution

and the report shall be made within twenty-four hours after he suspects or believes such person to be so infected.

Duplicate
report

(3) A copy or statement of every report made under this section shall be forwarded to the Minister and to the medical officer of health of the municipality in which such person resided before being admitted to such institution by the physician making the report. R.S.O. 1970, c. 479, s. 7.

Examination
of person in
custody or
committed
to prison

8. When a medical officer of health believes that any person under arrest or in custody, whether awaiting trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, by-law or order made thereunder or serving the sentence of a court upon conviction of any such offence or contravention, has been or may be infected or has been exposed to infection with venereal disease, he may cause such person to undergo such examination as may be necessary in order to ascertain whether or not such person is infected with venereal disease or to ascertain the extent of infection with venereal disease, and may direct that such person shall remain in custody until the results of the examination are known. R.S.O. 1970, c. 479, s. 8.

Treatment
where
disease
found to
exist

9. Where any person under arrest or in custody, whether awaiting trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, by-law or order made thereunder or serving the sentence of a court upon conviction of any such offence or contravention, is found to be infected with venereal disease, the medical officer of health may by order in writing direct that such person undergo treatment therefor and that such action be taken as the medical officer of health or the Minister may consider advisable for his isolation and the prevention of infection by him, and that he be detained in custody until cured or until he has received a degree of treatment considered adequate by the attending physician and the Minister notwithstanding that he may be otherwise entitled to be released, and any order made under this section is sufficient warrant to the person to whom the order is addressed to carry out the terms thereof. R.S.O. 1970, c. 479, s. 9.

Physician
to report
person
refusing to
continue
treatment

10.—(1) Where a person who has been under treatment for venereal disease refuses or neglects to continue treatment in a manner and to a degree satisfactory to the attending physician and the Minister, the physician shall report to the Minister the name and address of such person together with such other information as may be required by the regulations.

(2) A person who fails to attend upon his physician within seven days of an appointment for treatment shall be presumed to have neglected to continue treatment and the attending physician shall report such failure in writing to the Minister and the medical officer of health within fourteen days of the appointment.

Failure
to attend
within
seven days

(3) A physician who fails to report as required by this section is guilty of an offence and is liable to a fine of not less than \$25 and not more than \$100. R.S.O. 1970, c. 479, s. 10.

Offence

11.—(1) No person other than a physician shall attend upon or prescribe for or supply or offer to supply any drug, medicine, appliance or treatment to or for a person suffering from venereal disease for the purpose of the alleviation or cure of such disease.

Supply of
drugs, etc.,
by unquali-
fied persons
prohibited

(2) Every person who contravenes subsection (1) is guilty of an offence and is liable to a fine of not less than \$100 and not more than \$500 and in default of immediate payment shall be imprisoned for a term of not more than twelve months.

Offence

(3) Subsection (1) does not apply to a pharmacist licensed under Part VI of the *Health Disciplines Act* who dispenses to a patient of a physician upon a written prescription signed by such physician or who sells to any person any patent, proprietary or other medicine, drug or appliance approved by the regulations for the cure or alleviation of venereal disease, but no prescription shall be filled more than once except upon the written direction of the prescribing physician. R.S.O. 1970, c. 479, s. 11.

Exception
as to
pharmacist
R.S.O. 1980,
c. 196

12.—(1) Every person who,

Offences

- (a) wilfully neglects or disobeys any order or direction given by a medical officer of health or the Minister or Deputy Minister under this Act or the regulations;
- (b) hinders, delays or obstructs any medical officer of health, peace officer or other person acting in the performance of his duties under this Act;
- (c) publishes any proceedings taken under this Act or the regulations contrary to subsection (2);
- (d) wilfully represents himself as bearing some other name than his own or makes any false statements as to his ordinary place of residence during the

course of his treatment for any venereal disease with the purpose of concealing his identity;

(e) during the course of his treatment for any venereal disease changes his place of residence without giving due notice of such proposed change with his new address to the attending physician; or

(f) fails to comply with any of the provisions of this Act or the regulations,

is guilty of an offence and, where no other penalty is prescribed, is liable to a fine of not less than \$25 and not more than \$100 and in default of immediate payment shall be imprisoned for a term of not more than three months.

Prosecutions
R.S.O. 1980,
c. 400

(2) The *Provincial Offences Act* applies to prosecutions under this Act or the regulations but all proceedings for the recovery of penalties under this Act and proceedings authorized by section 6 shall be conducted *in camera* and no person shall publish or disclose any such proceedings except under the authority of this Act or the regulations.

Summons
by personal
service

(3) Notwithstanding the provisions of the *Provincial Offences Act*, service of any summons issued for a contravention of this Act may be effected by personal service. R.S.O. 1970, c. 479, s. 12.

Statements
as to
existence
of disease

13.—(1) Every person who publicly or privately, verbally or in writing, directly or indirectly, states or intimates that any other person has been notified or examined or otherwise dealt with under this Act, whether such statement or intimation is or is not true, is guilty of an offence, and in addition to any other penalty or liability, is liable to a fine of \$200 and in default of immediate payment shall be imprisoned for a term of not more than six months.

Exceptions

(2) Subsection (1) does not apply,

(a) to a communication or disclosure made in good faith,

(i) to the Minister or Deputy Minister of Health,

(ii) to a medical officer of health for his information in carrying out the provisions of this Act,

- (iii) to a physician,
- (iv) in the course of consultation for treatment for venereal disease,
- (v) to the superintendent or head of any place of detention;
- (b) to any evidence given in any judicial proceedings of facts relevant to the issue; or
- (c) to any communication authorized or required to be made by this Act or the regulations.

(3) Notwithstanding subsection (1), a physician may give information concerning the patient to other members of the patient's family for the protection of health. R.S.O. 1970, c. 479, s. 13. Information to family

14. Every person engaged in the administration of this Act shall preserve secrecy with regard to all matters that may come to his knowledge in the course of such employment and shall not communicate any such matter to any other person except in the performance of his duties under this Act or when instructed to do so by a medical officer of health or the Minister and in default he shall in addition to any other penalty forfeit his office or be dismissed from his employment. R.S.O. 1970, c. 479, s. 14. Obligation to observe secrecy

15. No person shall issue or make available to any person other than a physician or such persons as are engaged in the administration of this Act any laboratory report either in whole or in part of an examination made to determine the presence or absence of venereal disease. R.S.O. 1970, c. 479, s. 15. Laboratory reports

16. Every hospital receiving aid from the Province of Ontario, except isolation hospitals for the care of communicable diseases as defined by the *Public Health Act* shall make adequate provision for the reception, examination and treatment, upon such terms as may be prescribed, of such persons or classes of persons infected with venereal disease as may by this Act or the regulations be required or permitted to be treated at such hospital and in case of default the Treasurer of Ontario may withhold from any hospital the whole or any part of any grant or subsidy that would otherwise be payable. R.S.O. 1970, c. 479, s. 16. Hospitals to make provision for treatment, etc.
R.S.O. 1980, c. 409

17. The medical officer of health of each municipality shall make provision for the adequate treatment of all Provision for treatment

persons infected with venereal disease within such municipality when such persons apply or are referred to him or when requested to do so by the Minister. R.S.O. 1970, c. 479, s. 17.

Payment of
expenses by
municipi-
palities

18.—(1) The treasurer of the municipality shall forthwith upon demand, pay the amount of any account for services performed, materials or supplies furnished, or any expenditure incurred under the direction of the medical officer of health in carrying out the provisions of this Act and the regulations.

Secrecy as
to name

(2) The name of any person infected or suspected to be infected with any venereal disease shall not appear on any account in connection with treatment therefor, but the case shall be designated by a number and it is the duty of every local board of health to see that secrecy is preserved.

Offence

(3) Every person who contravenes the provisions of subsection (2) is guilty of an offence and is liable to the penalties provided by sections 13 and 14. R.S.O. 1970, c. 479, s. 18.

Transfer
to other
municipality

19. Where any direction or order of a medical officer of health or provincial judge involves the transfer of a person infected with venereal disease from one municipality to another municipality,

- (a) the medical officer of health of the second municipality shall, upon such transfer being effected and until the return of such person to the first municipality, exercise all the powers and perform all the duties conferred or imposed by this Act or the regulations upon a medical officer of health with respect to such person;
- (b) the liability of the first municipality under section 18 shall extend to any account for services performed, materials or supplies furnished, or any expenditure incurred in respect of such person under the direction of the medical officer of health for the second municipality in carrying out the provisions of this Act and the regulations; and
- (c) a duplicate original of every written report made by the person in medical charge of a place of detention in which such person is placed in the second municipality to the medical officer of health

thereof shall be sent forthwith to the medical officer of health of the first municipality. R.S.O. 1970, c. 479, s. 19.

20. Where a person is admitted to a place of detention under this Act, whether such admission is voluntary or under the order of a provincial judge or medical officer of health,

Places of
detention,
maintenance,
conduct

(a) subject to the regulations, the provisions of law relating to the liability for and payment of maintenance of patients, inmates or pupils in such place of detention apply; and

(b) such person is subject to all rules, regulations, and provisions of law governing the conduct of patients, inmates or pupils of such place of detention. R.S.O. 1970, c. 479, s. 20.

21.—(1) The consent only of any person of the age of sixteen years or over to being examined or treated or both for venereal disease shall be deemed to be sufficient consent for such purposes and where such consent is given no action or other proceeding lies against a physician for acting upon such consent.

Consent of
persons 16
or over to
treatment

(2) No action or other proceeding lies against a physician for acting upon a consent given by a person under sixteen years of age to be examined or treated or both for venereal disease if the physician had no reason to believe that the person giving the consent was under sixteen years of age. 1971, c. 33, s. 4.

Under 16

22. Where any person infected or believed to be infected with venereal disease is a child under the age of sixteen years, all notices, directions or orders required or authorized by this Act or by the regulations to be given in respect of the child shall be given to the father or mother or to the person having the custody of the child for the time being and it is the duty of the father, mother or other person to see that the child complies in every respect with every such notice, order or direction and in default thereof the father, mother or other person, as the case may be, is liable to the penalties provided by this Act or the regulations for non-compliance with any such notice, direction or order unless on any prosecution in that behalf it is proven to the satisfaction of the court that the father, mother or other person did everything in his power to cause the child to comply therewith. R.S.O. 1970, c. 479, s. 21.

Where
person
infected
is under
16 years
of age

Grants

23. The Minister may make grants out of such moneys as may be appropriated by the Legislature for the purpose,

- (a) for the establishment, equipment, operation and maintenance of clinics for the treatment of venereal disease and for the hospitalization, maintenance, treatment and special treatment of persons infected or suspected of being infected with venereal disease in addition to or in lieu of any other moneys that may be payable for such purposes; and
- (b) so as to reimburse municipalities for expenses incurred by such municipalities in supplying treatment to persons infected or suspected of being infected with venereal disease,

in such amounts, at such times and upon such conditions as may be prescribed by the regulations. R.S.O. 1970, c. 479, s. 22.

Regulations

24.—(1) The Lieutenant Governor in Council may make regulations,

- (a) prescribing the method and extent of the examination of any person for the purpose of ascertaining whether or not such person is infected with venereal disease or the extent of the infection;
- (b) prescribing the course of conduct to be pursued by any person infected with venereal disease in order to effect a cure and to prevent the infection of other persons;
- (c) prescribing the hospitals that shall furnish treatment to persons or any classes of persons infected with venereal disease;
- (d) prescribing rules for the treatment of persons infected with venereal disease in hospitals, places of detention and other places;
- (e) for preventing the spread of infection from persons suffering from venereal disease;
- (f) for distributing to physicians and hospitals information as to the treatment, diet and care of persons infected with venereal disease and requiring physicians and hospitals to distribute the information to such persons;

- (g) providing for the approval by the Minister of methods and remedies for the treatment, alleviation and cure of venereal disease;
- (h) providing for the display of notices and placards dealing with venereal disease, its cause, manifestation, treatment and cure;
- (i) prescribing the forms of notices, certificates and reports required or authorized to be given or issued under this Act;
- (j) requiring every physician to furnish reports with respect to the condition and treatment of persons infected with venereal disease who are or who have been under his diagnosis, treatment, care or charge;
- (k) prescribing the procedure to be followed and the evidence required in case of an appeal to the Minister from any action or decision of a medical officer of health under this Act;
- (l) approving patent, proprietary or other medicines, drugs or appliances for the cure or alleviation of venereal disease;
- (m) providing for the establishment, equipment, operation and maintenance of clinics for the treatment of venereal disease and for the treatment of persons infected or suspected of being infected with venereal disease;
- (n) requiring the approval of the Minister to the appointment of legally qualified medical practitioners, nurses and other technical staff employed in clinics for the treatment of venereal disease;
- (o) prescribing the amounts of, the times at which and the conditions upon which grants may be made for the establishment, equipment, operation and maintenance of clinics for the treatment of venereal disease and for the hospitalization, maintenance, treatment and special treatment of persons infected or suspected of being infected with venereal disease and for reimbursing municipalities for expenses incurred by such municipalities in supplying treatment to persons infected or suspected of being infected with venereal disease;
- (p) prescribing fees that shall be paid under this Act;

(g) prescribing the mode of sending or giving any notice, report or direction required or permitted to be sent or given by this Act or the regulations;

(r) generally for the better carrying out of the provisions of this Act and for the prevention, treatment and cure of venereal disease.

Expenses
of free
distribution

(2) The Minister may, out of any moneys appropriated by the Legislature for the purposes of this Act, provide for the payment of the expenses incurred in carrying out this Act and the regulations including the manufacture and free distribution to local boards of health, physicians and hospitals of any drug, medicine, appliance or instrument that the Minister may consider useful or necessary for the alleviation, treatment or cure of venereal disease or the prevention of infection therewith. R.S.O. 1970, c. 479, s. 23.

Appeal to
Minister

25.—(1) Every person who considers himself aggrieved by any action or decision of a medical officer of health under this Act may appeal therefrom to the Minister by giving notice in writing to the Minister and to the medical officer of health.

Evidence
on appeal

(2) The Minister may require the appellant to furnish such information and evidence and to submit to such examination as may be prescribed or as the Minister may consider necessary to determine the matter in dispute.

Decision
final

(3) The decision of the Minister is final. R.S.O. 1970, c. 479, s. 24.

Actions

26. No action or other proceeding shall be brought against any physician in respect of any examination or certificate given or required to be given by him under this Act, without the consent in writing of the Minister. R.S.O. 1970, c. 479, s. 25.

Right of
entry

27. The medical officer of health or a physician designated by him in writing for the purpose may enter in and upon any house, outhouse or premises in the day time for the purpose of making inquiry and examination with respect to the state of the health of any person therein and may cause any person found therein who is infected with any venereal disease to be removed to a place of detention or may give such directions as may prevent other persons in the same house, outhouse or premises from being infected. R.S.O. 1970, c. 479, s. 26.

28. The Deputy Minister of Health and any officer of the Ministry designated by the Minister are medical officers of health for Ontario within the meaning of this Act. Powers of Deputy Minister
R.S.O. 1970, c. 479, s. 27; 1972, c. 1, s. 1.

29. The Minister may delegate to the Deputy Minister of Health or any other officer of the Ministry of Health any of the powers vested in him under this Act or the regulations. Delegation of powers
R.S.O. 1970, c. 479, s. 28; 1972, c. 1, s. 1.

30. The administration of this Act and the regulations shall not interfere with the course of justice in the case of any person under arrest or in custody previous to trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, by-law or order made thereunder, but where it is necessary for the purpose of any examination authorized or required by this Act, such person may be held in custody until the results of the examination are known. Administration of Act not to interfere with course of justice
R.S.O. 1970, c. 479, s. 29.

Appendice II

A Survey of STD Clinics in Canada



Canada Diseases Weekly Report

ISSN 0382-232X

Rapport hebdomadaire des maladies au Canada

Date of publication: September 25, 1982
Date de publication: 25 septembre 1982

Vol. 8-39

CONTAINED IN THIS ISSUE:

A Survey of Sexually Transmitted Disease Clinics in Canada	193
First National Conference on Sexually Transmitted Disease: Issues and Priorities	196

CONTENU DU PRÉSENT NUMÉRO:

Étude sur les cliniques de maladies transmises sexuellement au Canada	193
Première conférence nationale sur les maladies transmises sexuellement: Questions et priorités...	196

A SURVEY OF SEXUALLY TRANSMITTED DISEASE CLINICS IN CANADA

Introduction: During the summer of 1982, a preliminary investigation of the facilities, personnel, and services provided in Canada's sexually transmitted disease (STD) clinics was undertaken. It was hoped that the compilation of a national list of STD clinics with an examination of their facilities would open the lines of communication between the clinics and provide data for a national overview.

A questionnaire was sent to each of the 94 STD clinics located across the country and the results are based on the analysis of data from 73 completed questionnaires.

RESULTS

Public utilization: Per capita utilization of the clinics varied from 1/32 in the Yukon to 1/2854 in New Brunswick (this clinic will cease to operate soon because of low utilization). The actual number of patients seen per clinic in 1981 ranged from 20 to 23 688. The number of visits (which included follow-up visits) by patients ranged from 20 at a clinic in British Columbia to 24 901 at one in Alberta. An average of 92% of the patients attending STD clinics were heterosexual. Homosexual attendance varied widely, ranging from less than 0.5% to 80% per clinic. The average proportion of female patients (37%) was lower than that for male patients (63%).

Public accessibility: Public accessibility depends not only on location but also on the availability of public transit, parking facilities, and hours of operation. The clinics were housed in various types of buildings. Fifty-two percent (52%) were located in health unit offices, 32% in hospital complexes, 6% in primary health care clinics, and 10% in other types of buildings. The main floor of these buildings was the location for 59% of the clinics. Only 33% were specifically identified as "VD Clinic" or "STD Clinic". Thirty-four percent (34%) of the clinics did not have free parking although 92% were easily accessible by public transit. Approximately 38% operated 5 days a week for an average of 5 hours a day. While evening and weekend hours would increase accessibility for clients working full-time, most of the clinics operated primarily during the day. However, 36% did have evening hours and 3% operated during the weekend. Of those clinics with evening hours, 73% were open for less than 5 hours per week during the evening. The range of operating hours varied from 1.5 hours per week in an Ontario clinic to 88 hours per week in one in Manitoba.

ÉTUDE SUR LES CLINQUES DE MALADIES TRANSMISES SEXUELLEMENT AU CANADA

Introduction: Au cours de l'été 1982, on a entrepris, au Canada, une étude préliminaire sur les locaux, le personnel et les services des cliniques de maladies transmises sexuellement (MTS). En compilant une liste nationale des cliniques MTS et en examinant leurs locaux, on espérait ouvrir la communication entre les cliniques et fournir des données permettant d'obtenir un aperçu de la situation à l'échelle nationale.

Un questionnaire a été envoyé à chacune des 94 cliniques MTS dispersées dans tout le Canada. Les résultats reposent sur l'analyse des données recueillies dans les 73 questionnaires remplis.

RÉSULTATS

Fréquentation: La fréquentation des cliniques par habitant varie de 1/32 au Yukon à 1/2854 au Nouveau-Brunswick (cette dernière fermera d'ailleurs bientôt ses portes pour cause de faible fréquentation). En 1981, le nombre réel de patients par clinique allait de 20 à 23 688. Le nombre de visites par patient (y compris les visites de post observation) allait de 20, pour une clinique de Colombie-Britannique, à 24 901, pour une clinique d'Alberta. Une moyenne de 92% des patients ayant recours aux cliniques MTS étaient hétérosexuels. La fréquentation par les homosexuels variait énormément, soit de 0,5% à 80% par clinique. La proportion des femmes (37%) était, en moyenne, plus faible que celles des hommes (63%).

Accessibilité: L'accessibilité dépend non seulement du lieu, mais aussi de la disponibilité des services de transport en commun, des espaces de stationnement et des heures d'ouverture. Les cliniques se trouvent dans divers endroits: 52%, dans des bureaux d'unités sanitaires; 32%, dans des ensembles hospitaliers; 6%, dans des centres de soins primaires et 10%, dans d'autres types d'installations. En tout, 59% sont installées au rez-de-chaussée. Les appellations précises "Clinique MV" ou "Clinique MTS" ne désignent que 33% des cliniques. Trente-quatre pourcent (34%) n'offrent pas de stationnement gratuit; cependant, 92% sont d'accès facile par transport en commun. Environ 38% sont ouvertes 5 jours par semaine, en moyenne 5 heures par jour. Bien que des heures d'ouverture en soirée et en fin de semaine permettraient à ceux qui travaillent à plein temps de s'y rendre plus facilement, la plupart des cliniques n'ouvrent que pendant la journée. Toutefois, 36% reçoivent des patients en soirée et 3%, en fin de semaine. Parmi les cliniques ouvertes le soir, 73% ne le sont que pendant moins de 5 heures par semaine. Les heures d'ouverture par semaine varient entre 1,5 heure, dans une clinique de l'Ontario et 88 heures, dans une du Manitoba.

Funding: Most of the clinics (90%) had funding from their provincial governments while 8% were solely or additionally funded by local health units and 2% by a different source. Approximately 22% of the clinics had a second source of funding.

Personnel: Fourteen percent (14%) of the clinics, located in Quebec, Ontario, Saskatchewan and British Columbia, had only 1 staff member and 68% had no more than 5. Physicians were classified according to their training: 38% were family physicians, 28% listed a specialty in STD, 13% had another specialty, and 10% were Medical Officers of Health. Twenty-nine percent (29%) of the clinics, 67% of which are situated in British Columbia, had no physician on staff.

Nurses accounted for 49% of the time worked by all personnel in all of the clinics. On average, nurses spent 29% of their time on contact tracing; however, this time ranged from 0% to 80%.

Only 11% of the clinics, the majority of which were located in Ontario, had laboratory technicians.

Automated data handling: Only 1 of the clinics had a computerized filing system and only 2 of the respective health units had a computerized reporting system for STDs.

Diagnostic procedures: The percentage of STD clinics capable of carrying out specific laboratory procedures is presented in Table 1. The majority (42-68%) utilized the standard laboratory procedures, with the exception of the rapid plasma reagin test for syphilis; only 19% of the clinics used this procedure.

Financement: La plupart des cliniques (90%) sont subventionnées par leur gouvernement provincial, tandis que 8% sont financées entièrement ou partiellement par des unités sanitaires locales et qu 2% ont d'autres sources de financement. Environ 22% reçoivent de fonds d'une deuxième source.

Personnel: Au Québec, en Ontario, en Saskatchewan et en Colombie-Britannique, le personnel se compose d'un seul (1) membre dans 14% des cliniques et d'un maximum de 5 dans 68% des cas. Les médecins ont été classés selon leur formation: 38% sont médecins de famille; 28% se sont inscrits comme spécialistes dans un domaine des MTS, 13% dans une autre branche et 10% sont médecins hygiénistes. Dans 29% des cliniques, dont 67% en Colombie-Britannique, aucun médecin ne fait partie du personnel.

Les heures de travail des infirmières et des infirmiers représentent 49% du temps total consacré au travail par le personnel de toutes les cliniques. En moyenne, les infirmières et les infirmiers passent 29% de leur temps au dépistage des sujets contacts; le pourcentage varie toutefois de 0 à 80%.

Seulement 11% des cliniques, pour la plupart en Ontario, ont des techniciens de laboratoire parmi leur personnel.

Traitement de données automatisé: Une seule (1) clinique possède un système de fichiers informatisé et 2 des unités sanitaires concernées, un système informatisé de déclaration des MTS.

Méthodes diagnostiques: Le Tableau 1 donne le pourcentage de cliniques MTS effectuant des analyses de laboratoire précises. La majorité (42-68%) se servent des méthodes standard, exception faite du test rapide de réagine sur plasma pour détecter la syphilis qui n'est pratiquée que dans 19% des cliniques.

Table 1 - Percentage of STD Clinics Using Laboratory Procedures
Tableau 1 - Pourcentage des cliniques MTS se servant de méthodes d'analyse précises

Laboratory Procedure/ Méthode de laboratoire	Clinics Using Laboratory Procedure/ Cliniques se servant de la méthode d'analyse	
	Number/ Nombre	Percentage/ Pourcentage
Gram stain (<i>Neisseria gonorrhoeae</i>)/ coloration de Gram (<i>Neisseria gonorrhoeae</i>)	43	59% ^{a)}
darkfield exam (syphilis)/ examen à l'ultramicroscope (syphilis)	32	44%
wet mount (<i>Trichomonas vaginalis</i>)/ préparation humide (<i>Trichomonas vaginalis</i>)	39	53%
wet mount (<i>Candida albicans</i>)/ préparation humide (<i>Candida albicans</i>)	31	42%
rapid plasma reagin test/ test rapide de réagine sur plasma	14	19%
transport medium (for <i>N. gonorrhoeae</i>)/ milieu de transport (pour <i>N. gonorrhoeae</i>)	50	68%
direct media inoculation (for <i>N. gonorrhoeae</i>)/ inoculation directe des milieux (pour <i>N. gonorrhoeae</i>)	35	48%

a) includes 2 clinics who used methylene blue stain for *N. gonorrhoeae*/
comprend 2 cliniques qui se servent de la coloration au bleu de méthylène pour *N. gonorrhoeae*

The majority of the laboratory procedures for culturing organisms, serology and virology were available to the clinics in their own building or locality. Sixty-one percent (61%) of the hospital STD clinics were able to obtain the necessary services in the same building, a percentage considerably higher than for those in other locations.

Facilities for culturing *Chlamydia trachomatis* were reportedly available to the clinics in all provinces except British Columbia and Newfoundland.

Les cliniques peuvent faire faire la majorité des tests de laboratoire (cultures, sérologie et virologie) dans l'immeuble ou dans la localité où elles se trouvent. Quant aux cliniques MTS logées dans un hôpital, 61% d'entre elles peuvent faire effectuer les tests nécessaires dans l'immeuble même, soit un pourcentage considérablement plus élevé que pour celles situées ailleurs.

Selon les rapports, toutes les cliniques ont à leur disposition les installations nécessaires pour cultiver *Chlamydia trachomatis*, sauf celles établies en Colombie-Britannique et à Terre-Neuve.

Patient examinations: In 99% of the clinics where personnel took intraurethral specimens from male patients, 67% used cotton wool swabs, 44%, calcium alginate swabs, and 10%, bacteriologic loops.

Although 93% of the clinics reported that visualization of the cervix in female patients was routinely done, bimanual pelvic examinations were routinely performed in only 53%. Ninety-seven percent (97%) had suitable examining tables. When taking specimens from women for *N. gonorrhoeae*, cultures were taken sometimes or always from the vagina in 67% of the clinics, from the cervix in 67%, from the endocervix in 78%, from the urethra in 75%, from the anus in 84%, and from the pharynx in 92%.

Suggestions and comments: Of the 56 clinics who suggested possible improvements to their services, 29% listed a need for more current STD literature, 53% for the establishment or improvement of facilities, 5% for better record-keeping systems, and 11% for more convenient clinic hours. The most urgent need for 27% of the clinics was a microscope.

Acknowledgement: The cooperation and assistance of the participating STD clinics was greatly appreciated.

SOURCE: R Kung, N Olsen, L Pisko, AG Jessamine, MB, ChB, Bureau of Epidemiology, LCDC, Ottawa.

Comment: The geographic disparities described above indicate that Canada still has a long way to go to achieve a "standardized" system of STD diagnosis and treatment. The variations in per capita utilization merit further investigation. Most Canadian STD clinics prefer to operate under a cloak of anonymity. Perhaps they should attempt to "attract" clients. Their variation in location and hours of operation is as expected. As to whether clinics should be open during the evening or on the weekend is debatable. Nevertheless, clinics which operate for 1 or 2 hours a week serve no useful purpose.

The percentage of clinic physicians claiming a "specialty" in STD is interesting, particularly as there is no formal postgraduate STD training program in Canada. Nurses carry out most of the basic clinic work. It is disturbing that a significant number of clinics have no physician on staff, and only a few clinics include the services of a laboratory technician. The lack of essential laboratory equipment in "third world" laboratories is commonplace, but one does not expect to see a similar situation in Canada. Hence the finding that 27% of the clinics had an "urgent" need for a microscope needs investigation. The number of clinics that actively "pursued" the *Chlamydia trachomatis* organism should also be determined.

The results of the survey are both stimulating and encouraging and indicate some useful avenues for future STD research in Canada. The findings should also encourage the various clinics to open their lines of communication with each other.

In general, the results suggest that the infrastructure of many Canadian STD clinics could be improved. Hopefully, the professionals involved with the administration and day-to-day running of these clinics will pay heed to the survey findings.

The excellent response to the questionnaire is a testimony to the enthusiasm of the clinic personnel.

SOURCE: Alan S Meltzer, MB, ChB, Dip Venereology, Associate Director, Health Sciences Division, International Development Research Centre, Ottawa, Ontario.

Examens médicaux: Dans 99% des cliniques où le personnel prélève des échantillons intra-urétraux chez les patients masculins, 67% se servent d'écouvillons de coton hydrophile; 44%, d'écouvillons d'alginate de calcium et 10%, d'anses bactériologiques.

Bien que 93% des cliniques aient déclaré que la visualisation du col chez les patientes était un examen de routine, seulement 53% ont déclaré pratiquer de façon courante un examen pelvien bimanuel. Quarante-vingt-dix-sept pourcent (97%) possèdent des tables d'examen appropriées. Pour isoler *N. gonorrhoeae* chez les femmes, 67% des cliniques prélèvent parfois ou toujours des cultures du vagin; 67%, du col; 78% de l'endocervix; 75%, de l'urètre; 84% de l'anus et 92% du pharynx.

Suggestions et commentaires: Parmi les 56 cliniques qui ont proposé des moyens pour améliorer leurs services, 29% mentionnaient le besoin d'une documentation pertinente à jour; 53%, la création de nouvelles installations ou l'amélioration des locaux; 5%, de meilleurs systèmes de tenue des dossiers et 11%, des heures d'ouvertures plus appropriées. Se procurer un microscope est, pour 27% des cliniques, d'une importance primordiale.

Remerciements: Nous tenons à remercier les cliniques MTS qui ont répondu au questionnaire.

SOURCE: R Kung, N Olsen, L Pisko, AG Jessamine, BM, BCh, Bureau d'épidémiologie, LLCM, Ottawa.

Commentaires: Les disparités géographiques décrites ci-dessus démontrent que le Canada a encore beaucoup de chemin à faire avant d'en arriver à un système "normalisé" de diagnostic et de traitement des MTS. Les variations quant à la fréquentation par habitant méritent d'être étudiées plus à fond. La plupart des cliniques MTS au Canada ont choisi de fonctionner sous le couvert de l'anonymat; elles devraient peut-être essayer "d'attirer" la clientèle. La diversité qui existe entre l'emplacement des cliniques et leurs heures d'ouverture n'a rien d'étonnant. L'opportunité d'ouvrir des cliniques en soirée ou en fin de semaine est toutefois discutable. Néanmoins, celles qui n'ouvrent que pendant 1 heure ou 2 par semaine ne sont d'aucune utilité.

Le fait qu'un pourcentage de médecins travaillant dans ces cliniques ait déclaré avoir une "spécialisation" en MTS est particulièrement intéressant, étant donné qu'il n'existe au Canada aucun programme d'études supérieures dans ce domaine. Ce sont les infirmières et les infirmiers qui se chargent de la plus grande partie du travail de base. Il est inquiétant de constater qu'un nombre important de cliniques ne compte pas de médecin parmi leur personnel et que seules quelques cliniques ont un technicien de laboratoire. L'absence d'équipement essentiel dans les laboratoires du "tiers monde" est chose courante, mais on ne s'attend pas à rencontrer une telle situation au Canada. Le fait que 27% des cliniques avaient un besoin "pressant" de microscope mérite donc qu'on s'y attarde. Il faudrait aussi déterminer le nombre de cliniques qui "recherchaient" activement le microorganisme *Chlamydia trachomatis*.

Les résultats de l'étude sont à la fois stimulants et encourageants; ils mettent aussi en évidence les points qui devraient, à l'avenir, faire l'objet de recherches sur les MTS au Canada. Les conclusions de cette étude devraient également inciter les diverses cliniques à communiquer entre elles.

Dans l'ensemble, les résultats suggèrent qu'il y aurait lieu d'améliorer l'infrastructure de beaucoup de cliniques MTS au pays. Il est à souhaiter que les spécialistes chargés de la gestion et du fonctionnement quotidien de ces cliniques y verront.

L'excellente réponse au questionnaire témoigne de l'enthousiasme du personnel des cliniques.

SOURCE: Alan S Meltzer, BM, BCh, Vénérologue, Directeur-adjoint, Division des sciences de la santé, Centre de recherche et de développement international, Ottawa (Ontario).

ent examinations: In 99% of the clinics where person- took intraurethral specimens from male patients, 67% took intraurethral specimens from female patients, 67% of cotton wool swabs, 44% calcium alginate swabs, and bacteriologic loops.

Although 93% of the clinics reported that visualization of the cervix in female patients was routinely done, bi-manual pelvic examinations were routinely performed in 53%. When taking specimens from women for gonorrhoeae, cultures were taken sometimes or always in the vagina in 67% of the clinics, from the cervix in 75%, from the endocervix in 78%, from the urethra in 75%, and from the anus in 84%, and from the pharynx in 92%.

Suggestions and comments: Of the 56 clinics who suggested improvements to their services, 29% listed a need for better record-keeping, 53% for the establishment of a STD laboratory, 53% for the creation of new facilities or installations or "amplification" of local services, 5% for more convenient clinic hours. The urgent need for 27% of the clinics was a microscope.

Acknowledgement: The cooperation and assistance of the participating STD clinics was greatly appreciated.

SOURCE: R Kung, N Olsen, L Pisko, AG Jessamine, MB, CHB, Bureau of Epidemiology, LCDC, Ottawa.

The percentage of clinic physicians claiming a specialty in STD is interesting, particularly as there is no formal postgraduate STD training program in Canada. It is surprising that a significant number of clinics have no physician on staff, and only a few clinics include the services of a laboratory technician. The lack of essential laboratory equipment in "third world" laboratories is a major problem. Hence the finding that 27% of the clinics had an "urgent" need for a microscope needs investigation. The number of clinics that actively "pursued" the mydia trachomatis organism should also be determined.

The results of the survey are both stimulating and encouraging and indicate some useful avenues for future research in Canada. The findings should also encourage various clinics to open their lines of communication with other.

In general, the results suggest that the infrastructure of Canadian STD clinics could be improved. Hopefully, professionals involved with the administration and day-to-day running of these clinics will pay heed to the survey findings.

The excellent response to the questionnaire is a testimony to the enthusiasm of the clinic personnel.

SOURCE: Alan S Melitzer, MB, ChB, Dip Venerology, Associate Director, Health Sciences Division, International Development Research Centre, Ottawa, Ontario.

Examens médicaux: Dans 99% des cliniques où le personnel préleve des échantillons intra-urétraux chez les patients masculins, 67% se servent d'écouvillons de coton filé, 44% d'alginate et 67% de tampons de coton. Dans 75% des cliniques, on prélève des échantillons de l'urètre, 75% de l'endocervix, 78% du col, 78% de l'endocervix, 75% de l'urètre, 84% de l'anus et 92% du pharynx.

Bien que 93% des cliniques aient déclaré que la visualisation du col chez les patientes était un examen de routine, seulement 53% ont déclaré pratiquer de façon courante un examen pelvien bi-manuel. Quarante-sept pour cent (97%) possèdent des tables d'examen appropriées. Pour isoler *N. gonorrhoeae* chez les femmes, 67% des cliniques prélèvent parfois ou toujours des cultures du vagin, 67% du col, 78% de l'endocervix, 75% de l'urètre, 84% de l'anus et 92% du pharynx.

Suggestions et commentaires: Parmi les 56 cliniques qui ont proposé des moyens pour améliorer leurs services, 29% mentionnaient le besoin d'une documentation pertinente à jour, 53%, la création de nouvelles installations ou "amplification" des locaux, 5%, de meilleurs systèmes de tenue des dossiers et 11%, des heures d'ouvertures plus appropriées. Se procurer un microscope est, pour 27% des cliniques, d'une importance primordiale.

Remerciements: Nous tenons à remercier les cliniques MTS qui ont répondu au questionnaire.

SOURCE: R Kung, N Olsen, L Pisko, AG Jessamine, MB, ChB, Bureau d'épidémiologie, LCDC, Ottawa.

Commentaires: Les disparités géographiques décrites ci-dessus démontrent que le Canada a encore beaucoup de chemin à faire avant d'en arriver à un système "normalisé" de diagnostic et de traitement des MTS. Les variations quant à la fréquentation par habitant méritent d'être étudiées plus à fond. La plupart des cliniques MTS au Canada ont choisi de fonctionner sous le couvert de l'anonymat; elles devraient peut-être essayer "d'attirer" la clientèle. La diversité qui existe entre l'emplacement des cliniques et leurs heures d'ouverture n'a rien d'étonnant. L'opportunité d'ouvrir des cliniques en soirée ou en fin de semaine est tout à fait discutable. Néanmoins, celles qui n'ouvrent que pendant 1 heure ou 2 par semaine ne sont d'aucune utilité.

Le fait qu'un pourcentage de médecins travaillant dans ces cliniques ait déclaré avoir une "spécialisation" en MTS est particulièrement intéressant, étant donné qu'il n'existe au Canada aucun programme d'études supérieures dans ce domaine. Ce sont les infirmières et les infirmiers qui se chargent de la plus grande partie du travail de base. Il est inquiétant de constater qu'un nombre important de cliniques ne compte pas de médecin parmi leur personnel et que seules quelques cliniques ont un technicien de laboratoire. L'absence d'équipement essentiel dans les laboratoires du "tiers monde" est chose courante, mais on ne s'attend pas à rencontrer une telle situation au Canada. Le fait que 27% des cliniques aient un besoin "pressant" de microscope mérite donc qu'on s'y attarde. Il faudrait aussi déterminer le nombre de cliniques qui "recherchaient" activement le microorganisme *Chlamydia trachomatis*.

Les résultats de l'étude sont à la fois stimulants et encourageants. Ils mettent aussi en évidence les points qui devraient, à l'avenir, faire l'objet de recherches sur les MTS au Canada. Les conclusions de cette étude devraient également inciter les diverses cliniques à communiquer entre elles.

Dans l'ensemble, les résultats suggèrent qu'il y aurait lieu d'améliorer l'infrastructure de beaucoup de cliniques MTS au pays. Il est à souhaiter que les spécialistes chargés de la gestion et du fonctionnement quotidien de ces cliniques y verront.

L'excellente réponse au questionnaire témoigne de l'enthousiasme du personnel des cliniques.

SOURCE: Alan S Melitzer, BM, BCh, Vénérologue, Directeur adjoint, Division des sciences de la santé, Centre de recherche et de développement international, Ottawa (Ontario).

The majority of the laboratory procedures for culturing organisms, serology and virology were available to the clinics in their own building or locally. Sixty-one percent (61%) of the hospital STD clinics were able to obtain the necessary services in the same building, a percentage considerably higher than for those in other locations. Facilities for culturing Chlamydia trachomatis were reportedly available to the clinics in all provinces except British Columbia and Newfoundland.

Les cliniques peuvent faire la majorité des tests de laboratoire (cultures, sérologie et virologie) dans l'immeuble ou dans la localité où elles se trouvent. Quant aux cliniques MTS logées dans un hôpital, 61% d'entre elles peuvent faire effectuer les tests nécessaires dans l'immeuble même, soit un pourcentage considérablement plus élevé que pour celles situées ailleurs. Selon les rapports, toutes les cliniques ont à leur disposition les installations nécessaires pour cultiver Chlamydia trachomatis, sauf celles établies en Colombie-Britannique et à Terre-Neuve.

includes 2 clinics who used methylene blue stain for *N. gonorrhoeae*/ comprend 2 cliniques qui se servent de la coloration au bleu de méthylène pour *N. gonorrhoeae*

Method/Procédure/ Laboratory Procedure/ Clinics Using	Number/ Nombre/ de la méthode d'analyse/ Cliniques se servant	Percentage/ Pourcentage
Gram stain (Neisseria gonorrhoeae)/ coloration de Gram (Neisseria gonorrhoeae)	43	59% a)
darkfield exam (syphilis)/ examen à l'ultramicroscope (syphilis)	32	44%
wet mount (Trichomonas vaginalis)/ préparation humide (Trichomonas vaginalis)	39	53%
wet mount (Candida albicans)/ préparation humide (Candida albicans)	31	42%
rapid plasma reagin test/ test rapide de réagine sur plasma	14	19%
transport medium (for <i>N. gonorrhoeae</i>)/ milieu de transport (pour <i>N. gonorrhoeae</i>)	50	68%
direct media inoculation (for <i>N. gonorrhoeae</i>)/ inoculation directe des milieux (pour <i>N. gonorrhoeae</i>)	35	48%

Table 1 - Percentage of STD Clinics Using Laboratory Procedures
Tableau 1 - Pourcentage des cliniques MTS se servant de méthodes d'analyse précises

Funding: Most of the clinics (90%) had funding from their provincial governments while 8% were solely or additionally funded by local health units and 2% by a different source. Approximately 22% of the clinics had a second source of funding.

Personnel: Fourteen percent (14%) of the clinics, located in Quebec, Ontario, Saskatchewan and British Columbia, had only 1 staff member and 68% had no more than 5. Physicians were classified according to their training: 38% were family physicians, 28% listed a specialty in STD, 13% had another specialty, and 10% were Medical Officers of Health. Twenty-nine percent (29%) of the clinics, 67% of which are situated in British Columbia, had no physician on staff.

Nurses accounted for 49% of the time worked by all personnel in all of the clinics. On average, nurses spent 29% of their time on contact tracing; however, this time ranged from 0% to 80%.

Only 11% of the clinics, the majority of which were located in Ontario, had laboratory technicians.

Automated data handling: Only 1 of the clinics had a computerized filing system and only 2 of the respective health units had a computerized reporting system for STDs.

Diagnostic procedures: The percentage of STD clinics capable of carrying out specific laboratory procedures is presented in Table 1. The majority (42-68%) utilized the standard laboratory procedures, with the exception of the rapid plasma reagin test for syphilis; only 19% of the clinics used this procedure.

Financement: La plupart des cliniques (90%) ont subi financées par leur gouvernement provincial, tandis que 8% sont financées entièrement ou partiellement par des unités sanitaires locales et que 2% ont d'autres sources de financement. Environ 22% reçoivent des fonds d'une deuxième source.

Personnel: Au Québec, en Ontario, en Saskatchewan et en Colombie-Britannique, le personnel se compose d'un seul (1) membre dans 14% des cliniques et d'un maximum de 5 dans 68% des cas. Les médecins ont été classés selon leur formation: 38% sont des médecins de famille, 28% se sont inscrits comme spécialistes dans un domaine des MTS, 13% dans une autre branche et 10% sont médecins hygiénistes. Dans 29% des cliniques, dont 67% en Colombie-Britannique, aucun médecin ne fait partie du personnel.

Les heures de travail des infirmières et des infirmiers représentent 49% du temps total consacré au travail par le personnel de toutes les cliniques. En moyenne, les infirmières et les infirmiers passent 29% de leur temps au dépistage des sujets contacts; le pourcentage varie toutefois de 0 à 80%.

Seulement 11% des cliniques, pour la plupart en Ontario, ont des techniciens de laboratoire parmi leur personnel.

Traitement de données automatisé: Une seule (1) clinique possède un système de fichiers informatisé et 2 des unités sanitaires concernées, un système informatisé de déclaration des MTS.

Méthodes diagnostiques: Le Tableau 1 donne le pourcentage des cliniques MTS effectuant des analyses de laboratoire précises. La majorité (42-68%) se servent des méthodes standard, exception faite du test rapide de réagine sur plasma pour détecter la syphilis qui ne se pratique que dans 19% des cliniques.



Date of publication: September 25, 1982
Date de publication: 25 septembre 1982
Vol. 6-39

ISSN 0562-262X

CONTAINED IN THIS ISSUE:

- A Survey of Sexually Transmitted Disease
Clinics in Canada 193
- First National Conference on Sexually Transmitted Disease: Issues and Priorities 196

CONTENU DU PRESENT NUMERO:

- Etude sur les cliniques de maladies transmissibles sexuellement au Canada 193
- Première conférence nationale sur les maladies transmissibles sexuellement: Questions et priorités 196

A SURVEY OF SEXUALLY TRANSMITTED DISEASE CLINICS IN CANADA

Introduction: During the summer of 1982, a preliminary investigation of the facilities, personnel, and services provided in Canada's sexually transmitted disease (STD) clinics was undertaken. It was hoped that the compilation of a national list of STD clinics with an examination of their facilities would open the lines of communication between the clinics and provide data for a national overview.

A questionnaire was sent to each of the 94 STD clinics located across the country and the results are based on the analysis of data from 73 completed questionnaires.

RESULTS

Public utilization: Per capita utilization of the clinics varied from 1/32 in the Yukon to 1/2854 in New Brunswick (this clinic will cease to operate soon because of low utilization). The actual number of patients seen per clinic in 1981 ranged from 20 to 23 688. The number of visits (which included follow-up visits) by patients ranged from 20 at a clinic in British Columbia to 24 901 at one in Alberta. An average of 92% of the patients attending STD clinics were heterosexual. Homosexual attendance varied widely, ranging from less than 0.5% to 80% per clinic. The average proportion of female patients (37%) was lower than that for male patients (63%).

Public accessibility: Public accessibility depends not only on location but also on the availability of public transit, parking facilities, and hours of operation. The clinics were housed in various types of buildings. Fifty-two percent (52%) were located in health unit offices, 32% in hospital complexes, 6% in primary health care clinics, and 10% in other types of buildings. The main floor of these buildings was the location for 59% of the clinics. Only 33% were specifically identified as "VD Clinic" or "STD Clinic". Thirty-four percent (34%) of the clinics did not have free parking although 92% were easily accessible by public transit. Approximately 38% operated 5 days a week for an average of 5 hours a day. While evening and weekend hours would increase accessibility for clients working full-time, most of the clinics operated primarily during the day. However, 36% did have evening hours and 3% operated during the weekend. Of those clinics with evening hours, 73% were open for less than 5 hours per week during the evening. The range of operating hours varied from 1.5 hours per week in an Ontario clinic to 88 hours per week in one in Manitoba.

RESULTS

Frequencation: La fréquentation des cliniques par habitant varie de 1/32 au Yukon à 1/2854 au Nouveau-Brunswick (cette dernière fermera d'ailleurs bientôt ses portes pour cause de faible fréquentation). En 1981, le nombre réel de visites par patient (y compris les visites de post-observation) allait de 20, pour une clinique de Colombie-Britannique, à 24 901, pour une clinique d'Alberta. Une moyenne de 92% des patients ayant recours aux cliniques MTS étaient hétérosexuels. La fréquentation par les homosexuels variait énormément, soit de 0,5% à 80% par clinique. La proportion des femmes (37%) était, en moyenne, plus faible que celles des hommes (63%).

Accessibilité: L'accessibilité dépend non seulement du lieu, mais aussi de la disponibilité des services de transport en commun, des espaces de stationnement et des heures d'ouverture. Les cliniques se trouvent dans divers endroits: 52%, dans des bureaux d'unités sanitaires; 32%, dans des ensembles hospitaliers; 6%, dans des centres de soins primaires et 10%, dans d'autres types d'installations. En tout, 59% sont installées au rez-de-chaussée. Les appellations précises "Clinique MV" ou "Clinique MTS" ne désignent que 33% des cliniques. Trente-quatre pourcent (34%) n'offrent pas de stationnement gratuit; cependant, 92% sont d'accès facile par transport en commun. Environ 38% sont ouvertes 5 jours par semaine, en moyenne 5 heures par jour. Bien que des heures d'ouverture en soirée et en fin de semaine permettaient à ceux qui travaillent à plein temps de s'y rendre plus facilement, la plupart des cliniques n'ouvrent que pendant la journée. Toutefois, 36% reçoivent des patients en soirée et 3%, en fin de semaine. Parmi les cliniques ouvertes le soir, 73% ne le sont que pendant moins de 5 heures par semaine. Les heures d'ouverture varient de 1,5 heures par semaine à 88 heures, dans une clinique de l'Ontario et 88 heures, dans une du Manitoba.

Etude sur les cliniques
antivénériennes au Canada

Annexe II

28. The Deputy Minister of Health and any officer of Deputy Powers of the Ministry designated by the Minister are medical officers of health for Ontario within the meaning of this Act.

29. The Minister may delegate to the Deputy Minister of Health or any other officer of the Ministry of Health any of the powers vested in him under this Act or the regulations.

30. The administration of this Act and the regulations shall not interfere with the course of justice in the case of any person under arrest or in custody previous to trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, by-law or order made thereunder, but where it is necessary for the purpose of any examination authorized or required by this Act, such person may be held in custody until the results of the examination are known. R.S.O. 1970, c. 479, s. 29.

(g) prescribing the mode of sending or giving any notice, report or direction required or permitted to be sent or given by this Act or the regulations;

(r) generally for the better carrying out of the provisions of this Act and for the prevention, treatment and cure of venereal disease.

(2) The Minister may, out of any moneys appropriated by the Legislature for the purposes of this Act, provide for the payment of the expenses incurred in carrying out this Act and the regulations including the manufacture and free distribution to local boards of health, physicians and hospitals of any drug, medicine, appliance or instrument that the Minister may consider useful or necessary for the alleviation, treatment or cure of venereal disease or the prevention of infection therewith. R.S.O. 1970, c. 479, s. 23.

Expenses of free distribution

25.—(1) Every person who considers himself aggrieved by any action or decision of a medical officer of health under this Act may appeal therefrom to the Minister by giving notice in writing to the Minister and to the medical officer of health.

Appeal to Minister

(2) The Minister may require the appellant to furnish such information and evidence and to submit to such examination as may be prescribed or as the Minister may consider necessary to determine the matter in dispute.

Evidence on appeal

(3) The decision of the Minister is final. R.S.O. 1970, c. 479, s. 24.

Decision final

26. No action or other proceeding shall be brought against any physician in respect of any examination or certificate given or required to be given by him under this Act, without the consent in writing of the Minister. R.S.O. 1970, c. 479, s. 25.

Actions

27. The medical officer of health or a physician designated by him in writing for the purpose may enter in and upon any house, outhouse or premises in the day time for the purpose of making inquiry and examination with respect to the state of the health of any person therein and may cause any person found therein who is infected with any venereal disease to be removed to a place of detention or may give such directions as may prevent other persons in the same house, outhouse or premises from being infected. R.S.O. 1970, c. 479, s. 26.

Right of entry

- (g) providing for the approval by the Minister of methods and remedies for the treatment, alleviation and cure of venereal disease;
- (h) providing for the display of notices and placards dealing with venereal disease, its cause, manifestation, treatment and cure;
- (i) prescribing the forms of notices, certificates and reports required or authorized to be given or issued under this Act;
- (j) requiring every physician to furnish reports with respect to the condition and treatment of persons infected with venereal disease who are or who have been under his diagnosis, treatment, care or charge;
- (k) prescribing the procedure to be followed and the evidence required in case of an appeal to the Minister from any action or decision of a medical officer of health under this Act;
- (l) approving patent, proprietary or other medicines, drugs or appliances for the cure or alleviation of venereal disease;
- (m) providing for the establishment, equipment, operation and maintenance of clinics for the treatment of venereal disease and for the treatment of persons infected or suspected of being infected with venereal disease;
- (n) requiring the approval of the Minister to the appointment of legally qualified medical practitioners, nurses and other technical staff employed in clinics for the treatment of venereal disease;
- (o) prescribing the amounts of, the times at which and the conditions upon which grants may be made for the establishment, equipment, operation and maintenance of clinics for the treatment of venereal disease and for the hospitalization, maintenance, treatment and special treatment of persons infected or suspected of being infected with venereal disease and for reimbursing municipalities for expenses incurred by such municipalities in supplying treatment to persons infected or suspected of being infected with venereal disease;
- (p) prescribing fees that shall be paid under this Act;

Grants

23. The Minister may make grants out of such moneys as may be appropriated by the Legislature for the purpose,

(a) for the establishment, equipment, operation and maintenance of clinics for the treatment of venereal disease and for the hospitalization, maintenance, treatment and special treatment of persons infected or suspected of being infected with venereal disease in addition to or in lieu of any other moneys that may be payable for such purposes; and

(b) so as to reimburse municipalities for expenses incurred by such municipalities in supplying treatment to persons infected or suspected of being infected with venereal disease,

in such amounts, at such times and upon such conditions as may be prescribed by the regulations. R.S.O. 1970, c. 479, s. 22.

Regulations

24.—(1) The Lieutenant Governor in Council may make regulations,

(a) prescribing the method and extent of the examination of any person for the purpose of ascertaining whether or not such person is infected with venereal disease or the extent of the infection;

(b) prescribing the course of conduct to be pursued by any person infected with venereal disease in order to effect a cure and to prevent the infection of other persons;

(c) prescribing the hospitals that shall furnish treatment to persons or any classes of persons infected with venereal disease;

(d) prescribing rules for the treatment of persons infected with venereal disease in hospitals, places of detention and other places;

(e) for preventing the spread of infection from persons suffering from venereal disease;

(f) for distributing to physicians and hospitals information as to the treatment, diet and care of persons infected with venereal disease and requiring physicians and hospitals to distribute the information to such persons;

thereof shall be sent forthwith to the medical officer of health of the first municipality. R.S.O. 1970, c. 479, s. 19.

20. Where a person is admitted to a place of detention under this Act, whether such admission is voluntary or under the order of a provincial judge or medical officer of health, health,

(a) subject to the regulations, the provisions of law relating to the liability for and payment of maintenance of patients, inmates or pupils in such place of detention apply; and

(b) such person is subject to all rules, regulations, and provisions of law governing the conduct of patients, inmates or pupils of such place of detention. R.S.O. 1970, c. 479, s. 20.

21.—(1) The consent only of any person of the age of sixteen years or over to being examined or treated or both for venereal disease shall be deemed to be sufficient consent for such purposes and where such consent is given no action or other proceeding lies against a physician for acting upon such consent.

(2) No action or other proceeding lies against a physician for acting upon a consent given by a person under sixteen years of age to be examined or treated or both for venereal disease if the physician had no reason to believe that the person giving the consent was under sixteen years of age. 1971, c. 33, s. 4.

22. Where any person infected or believed to be infected with venereal disease is a child under the age of sixteen years, all notices, directions or orders required or authorized by this Act or by the regulations to be given in respect of the child shall be given to the father or mother or to the person having the custody of the child for the time being and it is the duty of the father, mother or other person to see that the child complies in every respect with every such notice, order or direction and in default thereof the father, mother or other person, as the case may be, is liable to the penalties provided by this Act or the regulations for non-compliance with any such notice, direction or order unless on any prosecution in that behalf it is proven to the satisfaction of the court that the father, mother or other person did everything in his power to cause the child to comply therewith. R.S.O. 1970, c. 479, s. 21.

persons infected with venereal disease within such municipality when such persons apply or are referred to him or when requested to do so by the Minister. R.S.O. 1970, c. 479, s. 17.

Payment of expenses by municipalities

18.—(1) The treasurer of the municipality shall forthwith upon demand, pay the amount of any account for services performed, materials or supplies furnished, or any expenditure incurred under the direction of the medical officer of health in carrying out the provisions of this Act and the regulations.

Secrecy as to name

(2) The name of any person infected or suspected to be infected with any venereal disease shall not appear on any account in connection with treatment therefor, but the case shall be designated by a number and it is the duty of every local board of health to see that secrecy is preserved.

Offence

(3) Every person who contravenes the provisions of subsection (2) is guilty of an offence and is liable to the penalties provided by sections 13 and 14. R.S.O. 1970, c. 479, s. 18.

Transfer to other municipality

19. Where any direction or order of a medical officer of health or provincial judge involves the transfer of a person infected with venereal disease from one municipality to another municipality,

(a) the medical officer of health of the second municipality shall, upon such transfer being effected and until the return of such person to the first municipality, exercise all the powers and perform all the duties conferred or imposed by this Act or the regulations upon a medical officer of health with respect to such person;

(b) the liability of the first municipality under section 18 shall extend to any account for services performed, materials or supplies furnished, or any expenditure incurred in respect of such person under the direction of the medical officer of health for the second municipality in carrying out the provisions of this Act and the regulations; and

(c) a duplicate original of every written report made by the person in medical charge of a place of detention in which such person is placed in the second municipality to the medical officer of health

(iii) to a physician,

(iv) in the course of consultation for treatment for venereal disease,

(v) to the superintendent or head of any place of detention;

(b) to any evidence given in any judicial proceedings of facts relevant to the issue; or

(c) to any communication authorized or required to be made by this Act or the regulations.

(3) Notwithstanding subsection (1), a physician may give information concerning the patient to other members of the patient's family for the protection of health. R.S.O. 1970, c. 479, s. 13.

14. Every person engaged in the administration of this Act shall preserve secrecy with regard to all matters that may come to his knowledge in the course of such employment and shall not communicate any such matter to any other person except in the performance of his duties under this Act or when instructed to do so by a medical officer of health or the Minister and in default he shall in addition to any other penalty forfeit his office or be dismissed from his employment. R.S.O. 1970, c. 479, s. 14.

15. No person shall issue or make available to any person other than a physician or such persons as are engaged in the administration of this Act any laboratory report either in whole or in part of an examination made to determine the presence or absence of venereal disease. R.S.O. 1970, c. 479, s. 15.

16. Every hospital receiving aid from the Province of Ontario, except isolation hospitals for the care of communicable diseases as defined by the *Public Health Act* shall make adequate provision for the reception, examination and treatment, upon such terms as may be prescribed, of such persons or classes of persons infected with venereal disease as may by this Act or the regulations be required or permitted to be treated at such hospital and in case of default the Treasurer of Ontario may withhold from any hospital the whole or any part of any grant or subsidy that would otherwise be payable. R.S.O. 1970, c. 479, s. 16.

17. The medical officer of health of each municipality shall make provision for the adequate treatment of all

course of his treatment for any venereal disease with the purpose of concealing his identity;

(e) during the course of his treatment for any venereal disease changes his place of residence without giving due notice of such proposed change with his new address to the attending physician; or

(f) fails to comply with any of the provisions of this Act or the regulations,

is guilty of an offence and, where no other penalty is prescribed, is liable to a fine of not less than \$25 and not more than \$100 and in default of immediate payment shall be imprisoned for a term of not more than three months.

Prosecutions
R.S.O. 1980,
c. 400

(2) The *Provincial Offences Act* applies to prosecutions under this Act or the regulations but all proceedings for the recovery of penalties under this Act and proceedings authorized by section 6 shall be conducted in camera and no person shall publish or disclose any such proceedings except under the authority of this Act or the regulations.

Summons
by personal
service

(3) Notwithstanding the provisions of the *Provincial Offences Act*, service of any summons issued for a contravention of this Act may be effected by personal service. R.S.O. 1970, c. 479, s. 12.

Statements
as to
existence
of disease

13.—(1) Every person who publicly or privately, verbally or in writing, directly or indirectly, states or intimates that any other person has been notified or examined or otherwise dealt with under this Act, whether such statement or intimation is or is not true, is guilty of an offence, and in addition to any other penalty or liability, is liable to a fine of \$200 and in default of immediate payment shall be imprisoned for a term of not more than six months.

Exceptions

(2) Subsection (1) does not apply,

(a) to a communication or disclosure made in good faith,

(i) to the Minister or Deputy Minister of Health,

(ii) to a medical officer of health for his information in carrying out the provisions of this Act,

(2) A person who fails to attend upon his physician within seven days of an appointment for treatment shall be presumed to have neglected to continue treatment and the attending physician shall report such failure in writing to the Minister and the medical officer of health within fourteen days of the appointment.

(3) A physician who fails to report as required by this section is guilty of an offence and is liable to a fine of not less than \$25 and not more than \$100. R.S.O. 1970, c. 479, s. 10.

11.—(1) No person other than a physician shall attend upon or prescribe for or supply or offer to supply any drug, medicine, appliance or treatment to or for a person suffering from venereal disease for the purpose of the alleviation or cure of such disease.

(2) Every person who contravenes subsection (1) is guilty of an offence and is liable to a fine of not less than \$100 and not more than \$500 and in default of immediate payment shall be imprisoned for a term of not more than twelve months.

(3) Subsection (1) does not apply to a pharmacist licensed under Part VI of the *Health Disciplines Act* who dispenses to a patient of a physician upon a written prescription signed by such physician or who sells to any person any patent, proprietary or other medicine, drug or appliance approved by the regulations for the cure or alleviation of venereal disease, but no prescription shall be filled more than once except upon the written direction of the prescribing physician. R.S.O. 1970, c. 479, s. 11.

12.—(1) Every person who,

- (a) willfully neglects or disobeys any order or direction given by a medical officer of health or the Minister or Deputy Minister under this Act or the regulations;
- (b) hinders, delays or obstructs any medical officer of health, peace officer or other person acting in the performance of his duties under this Act;
- (c) publishes any proceedings taken under this Act or the regulations contrary to subsection (2);
- (d) willfully represents himself as bearing some other name than his own or makes any false statements as to his ordinary place of residence during the

Offences —

and the report shall be made within twenty-four hours after he suspects or believes such person to be so infected.

(3) A copy or statement of every report made under this section shall be forwarded to the Minister and to the medical officer of health of the municipality in which such person resided before being admitted to such institution by the physician making the report. R.S.O. 1970, c. 479, s. 7.

8. When a medical officer of health believes that any person under arrest or in custody, whether awaiting trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, by-law or order made thereunder or serving the sentence of a court upon conviction of any such offence or contravention, has been or may be infected or has been exposed to infection with venereal disease, he may cause such person to undergo such examination as may be necessary in order to ascertain whether or not such person is infected with venereal disease or to ascertain the extent of infection with venereal disease, and may direct that such person shall remain in custody until the results of the examination are known. R.S.O. 1970, c. 479, s. 8.

8. Where any person under arrest or in custody, whether awaiting trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, by-law or order made thereunder or serving the sentence of a court upon conviction of any such offence or contravention, is found to be infected with venereal disease, the medical officer of health may by order in writing direct that such person undergo treatment therefor and that such action be taken as the medical officer of health or the Minister may consider advisable for his isolation and the prevention of infection by him, and that he be detained in custody until cured or until he has received a degree of treatment considered adequate by the attending physician and the Minister notwithstanding that he may be otherwise entitled to be released, and any order made under this section is sufficient warrant to the person to whom the order is addressed to carry out the terms thereof. R.S.O. 1970, c. 479, s. 9.

10.—(1) Where a person who has been under treatment for venereal disease refuses or neglects to continue treatment in a manner and to a degree satisfactory to the attending physician and the Minister, the physician shall report to the Minister the name and address of such person together with such other information as may be required by the regulations.

Duplicate report

Examination of person in custody or committed to prison

Treatment where disease found to exist

Physician to report person refusing to continue treatment

(b) is infected with a venereal disease and refuses or neglects to take or continue treatment as required by this Act and the regulations,

he shall order that such person be admitted to and detained in a place of detention for such period not exceeding one year as the provincial judge may consider necessary.

(6) In any inquiry under this section, a certificate as to the result of any test made, signed or purporting to be signed by the director of a laboratory approved by the Minister is *prima facie* evidence of the facts stated therein and of the authority of the person giving such certificate without any proof of appointment or signature.

(7) Any person detained under this section may, with the approval in writing of the Minister, be brought before a provincial judge at any time during the last thirty days of the period for which he is so detained, and if the judge finds that he is still infected with venereal disease and in need of further treatment, he may order that such person be further detained for such period not exceeding one year as the judge may consider necessary.

(8) Where the Minister is of the opinion that any person detained under this section is no longer infected with venereal disease or has received an adequate degree of treatment, he may direct the discharge of such person.

7.—(1) Where any physician in medical charge of any correctional institution, lock-up or training school, has reason to believe that any person under his charge may be infected with venereal disease or has been exposed to infection with venereal disease, he may, and if he is, directed by the medical officer of health, he shall cause such person to undergo such examination as may be necessary to ascertain whether or not he is infected with venereal disease or to ascertain the extent of venereal disease infection and if the examination discloses that he is so infected the physician shall report the facts to the medical officer of health who may thereupon exercise the powers vested in him by section 9.

(2) Where an examination has not been made under this section, every physician in medical charge of any correctional institution, lock-up, or training school, shall report to the medical officer of health the name and place of confinement of any person under his charge whom he suspects or believes to be infected with venereal disease

Duty of physician in charge of institution

Examination by physician in charge of institution

Discharge by Minister

Extension of detention

Laboratory certificate as *prima facie* evidence

indicate that such person is or may be infected with venereal disease,

the medical officer of health may, whether or not laboratory findings indicate the presence of venereal disease, proceed in the manner prescribed in clauses 4 (3) (a) and (b). 1971, c. 33, s. 3.

(2) For the purposes of subsection (1), a medical officer of health may administer an oath and take a statement of health may administer an oath and take a statement under oath. R.S.O. 1970, c. 479, s. 5 (2).

6.—(1) Any medical officer of health may make a complaint or lay an information in writing and under oath before a justice of the peace charging that the circumstances set out in clause (5) (a) or (b) exist with regard to any person named in such complaint or information.

(2) Upon receiving any such complaint or information, the justice of the peace shall hear and consider the allegations of the complainant, and if he considers it desirable or necessary the evidence of any witness or doing is made out he shall issue a summons directed to the person complained of requiring him to appear before a provincial judge at a time and place named therein.

(3) Where a person to whom a summons is directed does not appear at the time and place named therein or where it appears that a summons cannot be served, a provincial judge may issue a warrant directing that the person named in the summons be brought before him.

(4) Where a person appears or is brought before a provincial judge under this section, the judge shall inquire into the truth of the matters charged in the complaint or information and for such purpose shall proceed in the manner prescribed by the *Provincial Offences Act* and has the powers of a provincial judge holding a hearing under that Act.

(5) Where a provincial judge finds that any person, (a) is infected with a venereal disease and is unwilling or unable to conduct himself in such a manner as not to expose other persons to the danger of infection; or

and may require such person to produce from time to time evidence satisfactory to the medical officer of health that he is undergoing adequate medical treatment and is in other respects carrying out such directions, and where such person fails to comply with the course of conduct prescribed for him or to produce the evidence required, the medical officer of health may exercise all the powers vested in him by clause (b) or may proceed under section 6; or

(b) with the approval of the Minister, order in writing that such person be removed and detained in a place of detention for the prescribed treatment until such time as the medical officer of health is satisfied that an adequate degree of treatment has been attained.

(4) Where a medical officer of health makes an order under clause (3) (b), he shall deliver the order to a peace officer who shall thereupon take the person named in the order into his custody and remove him to the place of detention named in the order, and the person for the time being in charge of the place of detention, upon receiving the order, shall receive such person and shall detain him until he is authorized by the medical officer of health to release him.

(5) A medical officer of health may adopt the procedure or do any of the acts referred to in subsection (3) with regard to any person who has been examined by a physician at any time within one year previously and has been certified by such physician to be infected with syphilis.

(6) A medical officer of health may require a person whom he believes may be infected with venereal disease to undergo more than one examination in order to determine the presence or absence of such infection. R.S.O. 1970, c. 479, s. 4.

5.—(1) Where,

(a) any person has been named under oath as a source or contact of venereal disease or is believed by the medical officer of health to be a source or contact of such venereal disease; and
(b) in the opinion of the medical officer of health the clinical findings and history of such person

Authority of
M.O.H.

Duties of
peace officer
on order
of m.o.h.

More
than one
examination
may be
required

3.—(1) It is the duty of,

(a) every physician;

(b) every superintendent or head of a hospital, sanatorium or laboratory; and

(c) every person in medical charge of any correctional institution, lock-up, training school, school or college or other similar institution,

to report within twenty-four hours every case of venereal disease coming under his diagnosis, treatment, care or charge for the first time to the medical officer of health in the locality in which such diagnosis, treatment, care or charge is made.

(2) Every person required to report a case of venereal disease under subsection (1) shall make such report in writing, by telephone, or in person to the medical officer of health.

(3) The report referred to in subsection (2) shall within one week of being received by the medical officer of health be forwarded in the prescribed form to the Minister.

4.—(1) Where a medical officer of health has reasonable grounds for believing that a person within the municipality is or may be infected with venereal disease or has been exposed to infection, the medical officer of health may give notice in writing in the prescribed form to such person directing him to submit to an examination by a physician designated by or satisfactory to the medical officer of health, and to procure and produce to the medical officer of health within the time specified in the notice a report or certificate of the physician that such person is or is not infected with venereal disease.

(2) Every person who without reasonable excuse, the proof of which is upon him, fails to comply with a direction made under subsection (1) is guilty of an offence and liable to imprisonment for a term of not less than seven days and not more than twelve months.

(3) If by the report or certificate mentioned in subsection (1) it appears that the person so notified is infected with venereal disease, the medical officer of health may,

(a) deliver to such person directions in the prescribed form as to the course of conduct to be pursued

Duty to report

Method of reporting

Report to Minister

Action of m.o.h. on reasonable belief

Offence

Powers of m.o.h. on report

Venerel Diseases Prevention Act

CHAPTER 521

1. In this Act,

(a) "medical officer of health" means a medical officer of health appointed under the *Public Health Act*; R.S.O. 1980, c. 409

(b) "Minister" means the Minister of Health;

(c) "place of detention" means a hospital, sanatorium, correctional institution, lock-up, Ontario training school, or any place designated as a place of detention by the Lieutenant Governor in Council but does not include an isolation hospital for the care of communicable diseases, other than venereal disease, as defined by the *Public Health Act*;

(d) "physician" means a legally qualified medical practitioner;

(e) "prescribed" means prescribed by the regulations;

(f) "regulations" means the regulations made under this Act or the *Public Health Act*;

(g) "venereal disease" means syphilis, gonorrhoea, chan-croid, granuloma inguinale or lymphogranuloma venereum. R.S.O. 1970, c. 479, s. 1; 1971, c. 33, s. 1.

2.—(1) Every person infected with venereal disease upon becoming aware or suspecting that he is so infected shall place himself forthwith under the care and treatment of a physician, and if unable to obtain such care or treatment he shall apply to the medical officer of health for the place in which he is ordinarily or temporarily resident.

(2) Every such person shall conduct himself in such a manner as not to expose other persons to the danger of infection, and shall take and continue treatment in a manner and to an extent considered to be adequate by the attending physician and the Minister. R.S.O. 1970, c. 479, s. 2.

Interpre-tation

Ontario

the supervision of a physician.

1965 c99 s26

27 A person is guilty of an offence who

Offence

(a) fails to comply with section 2, 3, 4, 5 or 7, or a notice or direction given to him under section 8,

(b) without justification or excuse, publishes, discloses, exhibits or makes accessible to the public any report or document relating to proceedings required by this Act to be conducted in private or discloses any file, record, document, paper or information in contravention of section 24,

(c) contravenes section 26, or

(d) willfully represents himself as bearing some other name than his own or makes any false statement as to his ordinary place of residence during the course of his treatment for venereal disease with the purpose of concealing his identity.

1965 c99 s27

Penalty

28 A person who is guilty of an offence under this Act is liable to a fine of not more than \$200 and in default of payment to imprisonment for a term of not more than 90 days.

1965 c99 s28

Prosecution

29 No prosecution shall be taken against any person for an offence under this Act except with the consent of the Minister.

1965 c99 s29

proceedings referred to in subsection (1) or (2) unless the report or transcript forms part of the reasons for judgment given by a judge, is contained in a publication devoted primarily to the reporting of judicial decisions and does not disclose the name of any person who in those proceedings was alleged or shown to be or to have been infected with venereal disease.

24(1) In the public interest, any file, record, document or paper kept by any person in any place

(a) that indicates in any way that any person is or was infected or is or was suspected of or alleged to be infected, and

(b) that came into existence through any thing done under or pursuant to this Act or its predecessors,

shall not, without the written consent of the Minister, be disclosed to any person except to a person to whom its disclosure is or was necessary in the course of the administration of this Act or its predecessors.

(2) A person who is or has been employed or engaged in the administration of this Act shall not disclose or be compelled to disclose any information obtained by him in the course of the performance of his duties under this Act

(a) except at a trial of an accused for an offence against this Act or in proceedings under section 9, and

(b) in any other case, except on the written consent of the Minister.

25 Any notice permitted or required to be given under this Act may be given personally or by registered mail addressed to the addressee's last known address.

1965 c99 s25

Offences and Penalties

26(1) No person other than a physician shall attend on or prescribe, recommend, supply or offer to supply to or for any person any drug, medicine, treatment or thing for the alleviation or cure of venereal disease.

(2) Subsection (1) does not apply to

(a) a registered pharmaceutical chemist who dispenses a physician's prescription, or

(b) a registered nurse who acts on the instructions of or under

or other public institution, any portion of any hospital or institution under its jurisdiction or any house or building as a place of detention for the purposes of this Act.

1965 c.99 s.20

Protection against
disclosure

21 No action, prosecution or other proceeding lies against any person by reason of the making by him of any certificate, report, notice, information, oral or written statement, statutory declaration, communication or record indicating directly or indirectly that any other person is or was or may be or may have been infected with venereal disease, if it is made in good faith and in the course of the administration of this Act or the regulations.

1965 c.99 s.21

Administration of
Act

22 This Act shall be administered so as not to interfere with the course of justice in the case of a person under arrest or in custody prior to trial for a criminal offence except to the extent that it is necessary, for the purpose of this Act, to detain that person in custody until the clinical examination is completed.

1965 c.99 s.22

When proceedings
are private

23(1) All proceedings

(a) under sections 9 and 16, or

(b) pertaining to applications to the Court of Queen's Bench for an order in the nature of a prerogative writ arising out of any proceeding under section 9 or 16,

shall be conducted in private.

(2) In any proceedings

(a) pertaining to a prosecution for an offence against this Act or an appeal therefrom, or

(b) pertaining to applications to the Court of Queen's Bench for an order in the nature of a prerogative writ arising out of any prosecution for an offence against this Act, or an appeal from the granting or refusing of the order,

the court shall order that the whole or any part of the proceedings shall be held in private when it is shown to the court that the evidence to be given in the proceedings or part thereof will or is likely to indicate any person as being or having been infected with venereal disease and to reveal his identity and that the giving of that evidence in public will cause unnecessary hardship to the person in the circumstances.

(3) All records, transcripts and documents pertaining to any proceedings referred to in subsections (1) and (2) are confidential and shall not be made accessible for public inspection.

(4) No person shall make or publish a report or transcript of any

concordance with the schedule prescribed under clause (a) and prescribing the terms and conditions on which the fees may be paid;

(c) prescribing the forms of informations, certificates, warrants and orders to be used for the purpose of this Act;

(d) generally, for the carrying out of the provisions of this Act and for the prevention, treatment and cure of venereal diseases.

1965 c99 s17

18 The Minister may

(a) establish and maintain one or more venereal disease clinics in Alberta to be operated by the Division,

(b) subject to the *Public Service Act*, appoint physicians to be in charge of or to conduct examinations or to carry out or supervise treatment of persons for venereal disease at provincial clinics, and

(c) provide for the free distribution to hospitals and other institutions of any drug, medicine or thing for the diagnosis, treatment or cure of venereal disease or the prevention of infection therefrom.

1965 c99 s18

19 The Director may

(a) prescribe the form of reports and notices required or authorized to be given to or by the Director under this Act,

(b) appoint or engage physicians to conduct clinical examinations or perform or supervise the treatment for venereal disease of persons to whom notices are given under section 8, and persons released pursuant to section 16,

(c) provide for the distribution to physicians and hospitals of information as to the treatment and care of persons suffering from venereal disease, and

(d) provide for public advertising and placarding of information relating to the treatment and cure of venereal disease and the places where proper treatment can be obtained.

1965 c99 s19

20(1) Every approved hospital within the meaning of the *Hospitals Act* shall provide accommodation satisfactory to the Director for those persons infected or suspected of being infected with venereal disease that are assigned to it.

(2) The treatment for those persons shall be carried out under the directions given by the Director.

(3) The Lieutenant Governor in Council may designate any hospital

son detained in custody for treatment for venereal disease pursuant to

(a) section 9(4), or

(b) section 14(2) and who is otherwise entitled to be released.

(2) Notwithstanding anything in section 9 or 14, a provincial judge may, on application of which the Director has been given notice sufficient in the opinion of the provincial judge, order the release of a person detained for treatment on the conditions that the person

(a) attend for treatment at a specified provincial clinic or on a physician named in the order, and

(b) comply with the directions for treatment prescribed by the physician in charge of the provincial clinic or the named physician, as the case may be, until he is no longer infected with venereal disease.

(3) The Director or an officer of the Division authorized by the Director to do so may lay an information before a provincial judge stating that he has reason to believe that the person released pursuant to an order made under subsection (2) has failed to comply with a condition of the order.

(4) On receiving the information the provincial judge shall hear and consider the allegations of the informant and if he considers it necessary or desirable the evidence of any witness, and if he is of the opinion that a case for so doing has been made out, he shall issue his warrant to take the person named therein into custody and cause him to be taken to a place of detention and detained there for treatment until he is no longer infected with venereal disease.

(5) When a provincial judge is in receipt of a certificate of a physician that a person detained pursuant to subsection (4) is no longer infected with venereal disease, the provincial judge shall forthwith order the immediate release of that person.

(6) A person detained under subsection (4) is not precluded from making a further application for an order under subsection (2).

1955 c99 s16

General

17 The Lieutenant Governor in Council may make regulations

(a) prescribing a schedule of fees payable to physicians for services performed in reporting, diagnosing or treating cases of venereal disease and for drugs, medicines or appliances supplied to their patients;

(b) authorizing the Minister to pay fees to physicians in ac-

Examination of
convicted persons

14(1) When a person is in custody serving a sentence imposed on a conviction, a jail physician may cause him to undergo a clinical examination to determine whether or not he is infected with venereal disease and may order that the person remain in custody until the clinical examination is completed.

(2) When a physician certifies that a person in custody serving a sentence imposed on a conviction is infected

(a) the infected person shall undergo medical treatment for the disease and any action shall be taken that the jail physician considers advisable for his isolation and prevention of infection by him, and

(b) notwithstanding that he may otherwise be entitled to be released, he shall be detained in custody for treatment until he is no longer infected.

(3) When a physician is of the opinion that a person detained for treatment under this section is no longer infected with venereal disease, the physician shall forthwith issue a certificate to that effect and cause it to be delivered immediately to the jailer, director, superintendent, constable or officer having the care and custody of the person so detained.

(4) A certificate issued under subsection (3) is sufficient warrant and authority to the jailer, director, superintendent, constable or officer having the care and custody of that person to release him from custody if he is otherwise entitled to be released.

1965 c99 s14

Physician's
certificates, orders

15(1) A certificate made under section 13(2) or 14(2) shall be based either on the clinical examination or on the results of laboratory tests.

(2) An order of a jail physician or a certificate of a physician under section 13 or 14 is sufficient warrant to the jailer, director, superintendent, constable or officer having the care and custody of the person so charged or convicted to detain that person until the clinical examination is completed and, in the case of a convicted person found to be infected, to carry out the provisions of section 14(2).

(3) An infected person required to undergo medical treatment under section 13 or 14 shall comply with all directions given by a jail physician as to treatment and every jailer, director, superintendent, constable and officer having the care and custody of an infected person shall see that the directions of the jail physician are carried out.

1965 c99 s15

Release from
detention

16(1) In this section "person detained for treatment" means a per-

is and shall be admitted in evidence as prima facie proof of that fact and that the person making it is a physician, without the necessity of proving the qualifications or signature of the physician making it.

12 When the ground or one of the grounds on which an information is laid under section 9 is that the person against whom the proceedings are taken has been named in a statutory declaration as a probable source or contact of venereal disease

(a) it is not necessary that the declaration be an exhibit to the information, and

(b) neither the person against whom the proceedings are taken, his counsel or agent is entitled in those proceedings, or in any proceedings in the Court of Queen's Bench for an order in the nature of a prerogative writ arising out of proceedings under section 9, to inspect the declaration or ascertain the name of the declarant,

but the judge may request that the declaration be produced to him for examination as to its validity or sufficiency.

13(1) When a person is under arrest or in custody and charged with a criminal offence, a jail physician may cause him to undergo a clinical examination to determine whether or not he is infected with venereal disease

(a) if that person is charged under any of the following provisions of the *Criminal Code* (Canada):

(i) paragraph 175(1)(d) by reason of living wholly or in part on the avails of prostitution;

(ii) subsection 193(1);

(iii) paragraph 193(2)(a) or (b);

(iv) subsection 195(1),

or

(b) in any other case, if the Director or the jail physician has reason to believe that the person is or may have been exposed to infection with venereal disease.

and may order that the person remain in custody until the clinical examination is completed.

(2) When a physician certifies that the person examined is infected, the infected person shall undergo medical treatment for venereal disease but only while he is in custody and if he is not otherwise entitled to be released.

RSA 1970 c382 s12(1);1978 c13 s29

(2) On receiving the information the provincial judge shall hear and consider the allegations of the informant and if he considers it necessary or desirable the evidence of any witness, and if he is of the opinion that a case for so doing has been made out he shall issue his warrant to take the person named therein into custody and cause him to be taken to a place of detention and detained there

(a) for a clinical examination to determine whether he has venereal disease, and

(b) if he is found to be infected, for treatment for venereal disease until he is no longer infected.

(3) A person detained under subsection (2) shall be given a clinical examination forthwith on being so detained.

(4) The attending physician, immediately on completion of the clinical examination, shall issue and forward to a provincial judge a certificate stating that the person named therein either

(a) is infected with venereal disease, in which case he shall be detained for treatment until he is no longer infected,

(b) is not infected with venereal disease, in which case the provincial judge shall order his immediate release, or

(c) is not infected with venereal disease on the basis of the clinical examination only and without the result of laboratory tests being determined, in which case the provincial judge shall order his immediate release.

(5) When a provincial judge is in receipt of a certificate of a physician stating that a person detained for treatment under subsection (4)(a) is no longer infected with venereal disease, the provincial judge shall forthwith order the immediate release of that person.

10(1) If a person is released pursuant to section 9(4)(c) and the laboratory tests subsequently show that the person is infected, a further information may be laid under section 9(1)(b) and if the provincial judge issues his warrant,

(a) no clinical examination is necessary, and

(b) on being detained in a place of detention, the person is deemed to be detained pursuant to section 9(4)(a).

(2) In any case to which subsection (1) refers, the provincial judge may refuse the information if the application is made later than 7 days after the results of the laboratory tests are known.

11 In proceedings under section 9, the certificate of a physician stating that the person named therein is infected with venereal disease

Physician's
certificate as
evidence

Warrant after
laboratory tests

(a) shall specify the time at or within which the person is to attend, and

(b) may require more than one attendance for examination.

(3) When the notice requires attendance at the office of a named physician, the Director shall send a copy of it to that physician with directions to

(a) conduct a clinical examination of the person suspected of being infected,

(b) send any samples or specimens taken from the person's body to a laboratory for testing, and

(c) forward a certificate to the Director within a prescribed time stating whether or not, on the basis of the clinical examination and the laboratory tests, if any, the person examined is infected with venereal disease.

(4) When a person notified pursuant to subsection (1) is found to be infected by virtue of the certificate of a physician in charge of a provincial clinic or the named physician, as the case may be, or by virtue of the certificate of the person in charge of the laboratory where the tests were made, the Director or a physician in charge of a provincial clinic may by notice give directions to that person as to the course of conduct to be pursued by him in undergoing treatment for venereal disease.

(5) When it is intended to name a physician in a notice under this section, the Director shall consult that physician before doing so.

RSA 1970 c382 s9

Persons Required to Undergo Treatment

9(1) The Director or an officer of the Division authorized by the Director to do so may lay an information before a provincial judge stating that he has reason to believe that the person named therein is infected with venereal disease on any of the following grounds:

(a) that the person has failed to comply with a notice served on him under section 8(1) or (4);

(b) that the person has been found to be infected on the basis of a clinical examination or laboratory tests and has refused or neglected to submit to treatment or to continue treatment;

(c) that the person has been named in a statutory declaration as a probable source or contact of venereal disease;

(d) that in the opinion of the Director the clinical findings and history of the person indicate that he is or may be infected with venereal disease.

- (a) all positive and negative results of tests for syphilis made in the laboratory, and
- (b) all positive results of tests for gonorrhoea made in the laboratory,

within 48 hours of the time the results are determined.

RSA 1970 c382 56

6 Every physician who examines or treats a person for or in respect of venereal disease shall instruct him in measures for preventing the spread of the disease and inform him of the necessity for regular treatment until cured.

RSA 1970 c382 57

7(1) If an infected person under treatment for venereal disease by a physician refuses or neglects to continue his treatment in a manner and to a degree satisfactory to the physician, the physician shall forward a report to that effect to the Director unless he is sooner notified that the infected person is under treatment at a provincial clinic.

(2) A person who fails to attend on his physician within 7 days of an appointment for treatment for venereal disease shall be presumed to have neglected to continue his treatment and in that case the physician shall forward the report to the Director within 14 days of the appointment.

RSA 1970 c382 58

Notice to Attend for Examination and Treatment

8(1) When the Director has reasonable grounds for believing that a person is infected with venereal disease by virtue of

- (a) a report forwarded to him pursuant to section 4, 5 or 7,

- (b) the refusal or neglect of that person to continue treatment at a provincial clinic,

- (c) that person being named in a statutory declaration as a probable source or contact of venereal disease, or

- (d) any other proof or information in the possession of the Director,

the Director or a person authorized by the Director to do so may serve a notice on that person requiring him to attend at the provincial clinic nearest his residence or at the office of a named physician for examination for venereal disease and, if he is found to be infected, for treatment of the disease.

(2) A notice under subsection (1)

Duties of Infected Persons

2 Every person who knows or suspects or has reason to believe that he is or may be infected with venereal disease

Duty to take treatment

(a) shall immediately consult a physician or attend at a provincial clinic to determine whether he is infected or not, and
(b) if he is found to be infected, shall submit to the treatment that is directed by a physician or at a provincial clinic until he is no longer infected with venereal disease in the opinion of the physician consulted or the physician in charge of a provincial clinic.

RSA 1970 c382 53

3 Every person who is required by section 2 to submit to treatment for venereal disease

Change of address or physician

(a) shall inform the physician consulted or the provincial clinic, as the case may be, of any change of his address occurring during the period of treatment, or
(b) if he is under treatment by a physician and wishes to discontinue treatment under that physician, shall immediately consult and submit to treatment by another physician or at a provincial clinic.

RSA 1970 c382 54

Duties of Physicians and Others

4(1) It is the duty of

Duty re reports

(a) every physician,
(b) every superintendent or head of a hospital or sanatorium, and
(c) every person in charge of medical services in a correctional institution, lock-up or reformatory or similar place or in an educational institution,

to report to the Director every case of infection with venereal disease coming under his diagnosis, treatment, care or charge for the first time.

(2) The report shall be completed and forwarded to the Director within 48 hours after the first diagnosis, treatment or knowledge by or of the physician, superintendent, head or other person.

RSA 1970 c382 55

5 The person in charge of a laboratory shall report to the Director

Report of laboratory tests

6608

VENEREAL DISEASES PREVENTION ACT

CHAPTER V-2

HER MAJESTY, by and with the advice and consent of the
Legislative Assembly of Alberta, enacts as follows:

Definitions

1 In this Act,

(a) "clinical examination" means an examination for venereal disease consisting of a physical examination, the taking of samples or specimens from the body on the same occasion as the physical examination and the testing of the samples or specimens at the place where the samples or specimens were taken;

(b) "Director" means the Director of the Division;

(c) "Division" means the Division of Social Hygiene of the Department of Social Services and Community Health;

(d) "infected" means having a venereal disease in a communicable stage;

(e) "jail physician" means a physician in attendance in his professional capacity at a correctional institution, lock-up, reformatory or similar place;

(f) "laboratory tests" means tests of samples or specimens from the body made in a laboratory at a place other than where the samples or specimens were taken;

(g) "Minister" means the Minister of Social Services and Community Health;

(h) "place of detention" means a hospital, sanatorium, correctional institution, lock-up, reformatory, or any place designated as a place of detention by the Lieutenant Governor in Council;

(i) "provincial clinic" means a venereal disease clinic operated by the Division;

(j) "venereal disease" means syphilis, gonorrhoea, chancre, granuloma inguinale or lymphopathia venereum.

RSA 1970 c382 s2;1971 c25 s19(1);1975(2) c12 ss8,9

Alberta

Subsection 34(2) is amended by the deletion of the words "Public Works and Highways" and the substitution therefor of the words "Highways and Public Works".

Clause 1(b) is amended by the deletion of the words "Department of Community Services" and substitution therefor of the words "Department of Community Affairs".

Clause 1(c) is amended by the deletion of the words "Minister of Community Services" and the substitution therefor of the words "Minister of Community Affairs".

Section 3 is amended by the deletion of the words "Provincial Secretary" and the substitution therefor of the words "Director of Corporations".

Sections 1(c)(vi), 2(2), 3(1), (2), (4) and (5), 4(3), 5(2) and (3), 6(1), (2) and (3), 7(1), (2) and (3), 16(1), (2), (3) and (4), 17, 18(1), (2) and (3), 19(1) and (3), 20, 21, 22, 23, 24(2) and (3), 25, 27(4) and 28 are amended by the deletion of the words "Provincial Secretary" wherever they appear and the substitution therefor in each case of the words "Director of Corporations".

Clause 1(c) is amended by the deletion of the words "Minister of Industry and Commerce" and the substitution therefor of the words "Minister of Tourism, Industry and Energy".

Clause 1(b) is amended by the deletion of the words "Minister of Health" and the substitution therefor of the words "Minister of Health and Social Services".

Section 24 is amended by the deletion of the words "Department of Health" and the substitution therefor of the words "Department of Health and Social Services".

Subsection 3(3) is amended by the deletion of the words "Minister of Municipal Affairs" and the substitution therefor of the words "Minister of Community Affairs".

Subsections 41(4) and (5) are amended by the deletion of the words "Department of Public Works and Highways" and "Minister of Public Works and Highways" and the substitution therefor of the words "Department of Highways and Public Works" respectively.

Subsection 26(1) is amended by the deletion of the words "Department of Health" and the substitution therefor of the words "Department of Health and Social Services".

Rural Community Fire Companies Act, R.S.P.E.I. 1974, Cap. R-16

Securities Act, R.S.P.E.I. 1974, Cap. S-4

Summary Trespas Act, R.S.P.E.I. 1974, Cap. S-11

Veneral Diseases Prevention Act, R.S.P.E.I. 1974, Cap. V-2

Village Service Act, R.S.P.E.I. 1974, Cap. V-5

Vital Statistics Act, R.S.P.E.I. 1974, Cap. V-6

(3) The decision of the Minister is final. 1974(2nd),c.92,s.21.

22. The Chief Health Officer or a physician or public health nurse designated by him in writing for the purpose may, with a warrant issued by a provincial judge, enter in and upon any house or premises for the purpose of making inquiry and examination with respect to the state of the health of any person therein and may cause any person found therein who is infected with any venereal disease to be removed to a place of detention or may give such direction as may prevent other persons in the same house or premises from being infected. 1974(2nd),c.92,s.22.

23. The Deputy Minister of Health and any officer of the department designated by the Minister are health officers within the meaning of this Act. 1974(2nd),c.92,s.23.

24. The Minister may delegate to the Deputy Minister of Health or any other officer of the Department of Health any of the powers vested in him under this Act or the regulations. 1974(2nd),c.92,s.24.

25. The administration of this Act and the regulations shall not interfere with the course of justice in the case of any person under arrest or in custody previous to trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, bylaw or order made thereunder, but where it is necessary for the purpose of any examination authorized or required by this Act, such person may be held in custody until the results of the examination are known. 1974(2nd),c.92,s.25.

(d) prescribing rules for the treatment of persons infected with venereal disease in hospitals, places of detention and other places;

(e) for preventing the spread of infection from persons suffering from venereal disease;

(f) for distributing to physicians and hospitals information as to the treatment, diet and care of persons infected with venereal disease and requiring physicians and hospitals to distribute the

information to such persons;

(g) providing for the approval by the Minister of methods and remedies for the treatment, alleviation and cure of venereal diseases;

(h) providing for the display of notices and placards dealing with venereal disease, its cause, manifestation, treatment and cure;

(i) prescribing the forms of notices, certificates and reports required or authorized to be given or issued under this Act;

(j) requiring every physician to furnish reports with respect to the condition and treatment of persons infected with venereal disease who are or who have been under his diagnosis, treatment, care or charge;

(k) prescribing the procedure to be followed and the evidence required in case of an appeal to the Minister from any action or decision under this Act;

(l) approving patent, proprietary or other medicines, drugs or appliances for the cure or alleviation of venereal disease;

(m) prescribing the mode of sending or giving any notice, report or direction required or permitted to be sent or given by this Act or the regulations;

(n) generally for the better carrying out of this Act, and for the prevention, treatment and cure of venereal disease.

(2) The Minister may, out of any moneys appropriated by the Legislature for the purposes of this Act, provide for the payment of the expenses incurred in carrying out this Act and the regulations including the manufacture and free distribution to physicians of any drug, medicine, appliance or instrument that the Minister may consider useful or necessary for the alleviation, treatment or cure of venereal disease or the prevention of infection therewith. 1974(2nd), c. 92, s. 20.

21. (1) Every person who considers himself aggrieved by any action or decision of the Chief Health Officer under this Act may appeal therefrom to the Minister by giving such notice in writing to the Minister and to the Chief Health Officer.

(2) The Minister may require the appellant to furnish such information and evidence and to submit to such examination as may be prescribed or as the Minister may consider necessary to determine the matter in dispute.

the whole or any part of any moneys that would otherwise be payable. 1974(2nd), c.92, s.16.

17. Where a person is admitted to a place of detention under this Act, whether the admission is voluntary or under the order of a provincial judge or the Chief Health Officer

Places of
detention,
maintenance,
conduct

(a) subject to the regulations, the provisions of law relating to the liability for and payment of maintenance of patients, inmates or pupils in such place of detention apply; and
(b) such person is subject to all rules, regulations, and provisions of law governing the conduct of patients, inmates or pupils of such place of detention. 1974(2nd), c.92, s.17.

18. (1) The consent of any person of the age of sixteen years or over to being examined or treated or both for venereal disease shall be deemed to be sufficient consent for such purposes and where such consent is given no action or other proceeding lies against a physician for acting upon such consent.

Consent of
persons 16 or
over to treatment

(2) No action or other proceeding lies against a physician for acting upon a consent given by a person under sixteen years of age to be examined or treated or both for venereal disease if the physician had no reason to believe that the person giving the consent was under sixteen years of age. 1974(2nd), c.92, s.18.

Under sixteen
years

19. Where any person infected or believed to be infected with venereal disease is a child under the age of sixteen years, all notices, directions or orders required or authorized by this Act or by the regulations to be given in respect of the child shall be given to the father or mother or to the person having custody of the child for the time being and it is the duty of the father, mother or other person to see that the child complies in every respect with every such notice, order or direction and in default thereof the father, mother or other person, as the case may be, is liable to the penalties provided by this Act or the regulations for non-compliance with any such notice, direction or order unless on any prosecution in that behalf it is proven to the satisfaction of the court that the father, mother or other person did everything in his power to cause the child to comply therewith. 1974(2nd), c.92, s.19.

Where person
infected is under
16 years of age

20. (1) The Lieutenant Governor in Council may make regulations
(a) prescribing the method and extent of the examination of any person for the purpose of ascertaining whether or not such person is infected with venereal disease or the extent of the infection;
(b) prescribing the course of conduct to be pursued by any person infected with venereal disease in order to effect a cure and to prevent the infection of other persons;
(c) prescribing the hospitals that shall furnish treatment to persons or any classes of persons infected with venereal disease;

Regulations

13. (1) Every person who publicly or privately, verbally or in writing, directly or indirectly, states or intimates that any other person has been notified or examined or otherwise dealt with under this Act, whether such statement or intention is or is not true, is guilty of an offence, and in addition to any other penalty or liability, is liable to a fine of two hundred dollars and in default of immediate payment shall be imprisoned for a term of not more than six months.

(2) Subsection (1) does not apply

Exception

(a) to a communication or disclosure made in good faith,
(i) to the Minister, Deputy Minister of Health or Chief Health Officer,
(ii) to a health officer or public health nurse for their information in carrying out this Act,
(iii) to a physician,
(iv) in the course of consultation for treatment for venereal disease,
(v) to the superintendent or head of any place of detention;

(b) to any evidence given in any judicial proceedings of facts relevant to the issue; or
(c) to any communication authorized or required to be made by this Act or the regulations;

(3) Notwithstanding subsection (1), a physician may give information concerning the patient to other members of the patient's family for the protection of health. 1974(2nd), c.92, s.13.

Information to family

14. Every person engaged in the administration of this Act shall preserve secrecy with regard to all matters that may come to his knowledge in the course of such employment and shall not communicate in such matter to any other person except in the performance of his duties under this Act or when instructed to do so by the Chief Health Officer or the Minister and in default he shall in addition to any other penalty forfeit his office or be dismissed from his employment. 1974(2nd), c.92, s.14.

Obligation to observe secrecy

15. No person shall issue or make available to any person other than a physician or such persons as are engaged in the administration of this Act any laboratory report either in whole or in part of an examination made to determine the presence or absence of venereal disease. 1974(2nd), c.92, s.15.

Laboratory reports

16. Every hospital receiving payment from the Province of Prince Edward Island shall make adequate provision for the reception, examination and treatment, upon such terms as may be prescribed, of such persons or classes of persons infected with venereal disease as may by this Act or the regulations be required or permitted to be treated at such hospital, and in case of default the Minister of Finance of Prince Edward Island may withhold from any hospital

Hospitals to make provision for treatment etc.

(2) Every person who contravenes subsection (1) is guilty of an offence and is liable to a fine of not less than one hundred dollars and not more than five hundred dollars and in default of immediate payment shall be imprisoned for a term of not more than twelve months.

(3) Subsection (1) does not apply to a registered pharmaceutical chemist who dispenses to a patient of a physician upon receipt of a written prescription signed by the physician or who sells to any person any patent, proprietary or other medicine, drug or appliance prescribed by a physician for the cure or alleviation of venereal disease, but no prescription shall be filled more than once except upon the written direction of the prescribing physician. 1974 (2nd), c.92, s.11.

12. (1) Every person who

(a) willfully neglects or disobeys any order or direction given by the Chief Health Officer or the Minister or Deputy Minister under this Act or the regulations;

(b) hinders, delays or obstructs any health officer, public health nurse, peace officer or other person acting in the performance of his duties under this Act;

(c) publishes any proceedings taken under this Act or the regulations contrary to subsection (2);

(d) willfully represents himself as bearing some other name other than his own or makes any false statements as to his ordinary place of residence during the course of his treatment for any venereal disease with the purpose of concealing his identity;

(e) during the course of his treatment for any venereal disease changes his place of residence without giving due notice of the proposed change with his new address to the attending physician; or

(f) fails to comply with this Act or the regulations;

is guilty of an offence and, where no other penalty is prescribed, is liable to a fine of not less than twenty-five dollars and not more than one hundred dollars and in default of immediate payment shall be imprisoned for a term of not more than three months.

(2) Part XXIV of the *Criminal Code* of Canada, R.S.C. 1970, Chap. C-34 is included herein as part of this Act and applies to prosecutions under this Act or the regulations but all proceedings for the recovery of penalties under this Act and proceedings authorized by section 6 shall be conducted *in camera* and no person shall publish or disclose any such proceedings except under the authority of this Act or the regulations.

(3) Notwithstanding the provisions of subsection (2), service of any summons issued for a contravention of this Act may be effected by personal service. 1974(2nd), c.92, s.12.

Exception as to chemists

Offences

Offence

Prosecutions

Summons by personal service

8. When the Chief Health Officer believes that any person under arrest or in custody, whether awaiting trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, bylaw or order made thereunder or serving the sentence of a court upon conviction of any such offence or contravention, has been or may be infected or has been exposed to infection with venereal disease, he may cause such person to undergo such examination as may be necessary in order to ascertain whether or not such person is infected with venereal disease, and may direct that such person shall remain in custody until the results of the examination are known. 1974(2nd), c.92, s.8.

9. Where any person under arrest or in custody, whether awaiting trial for any offence under, or contravention of, any statute of Canada or of the Legislature or any regulation, bylaw or order made thereunder or serving the sentence of a court upon conviction of any such offence, or contravention, is found to be infected with venereal disease, the Chief Health Officer may by order in writing direct that such person undergo treatment therefor and that such action be taken as the Chief Health Officer or the Minister may consider advisable for his isolation and the prevention of infection by him, and that he be detained in custody until cured or until he has received a degree of treatment considered adequate by the attending physician and the Minister, notwithstanding that he may be otherwise entitled to be released, and any order made under this section is sufficient warrant to the person to whom the order is addressed to carry out the terms thereof. 1974(2nd), c.92, s.9.

Treatment where disease found to exist

10. (1) Where a person who has been under treatment for venereal disease refuses or neglects to continue treatment in a manner and to a degree satisfactory to the attending physician and the Minister, the physician shall report to the Minister the name and address of such person together with such other information as may be required by the regulations.

Physician to report person refusing to continue treatment

(2) A person who fails to attend upon his physician within seven days of an appointment for treatment shall be presumed to have neglected to continue treatment and the attending physician shall report this failure in writing to the Minister and the Chief Health Officer within fourteen days of the appointment.

Failure to attend within seven days

(3) A physician who fails to report as required by this section is guilty of an offence and is liable to a fine of not less than one hundred dollars and not more than five hundred dollars, and in default of payment thereof to imprisonment for a term of not more than twelve months. 1974(2nd), c.92, s.10.

11. (1) No person other than a physician shall attend upon or prescribe for or supply or offer to supply any drug, medicine, appliance or treatment to or for a person suffering from venereal disease for the purpose of the alleviation or cure of such disease.

Supply of drugs, etc., by unqualified persons prohibited

(5) Where a provincial judge finds that any person (a) is infected with a venereal disease and is unwilling or unable to conduct himself in such a manner as not to expose other persons to the danger of infection; or (b) is infected with a venereal disease and refuses or neglects to take or continue treatment as required by this Act and the regulations;

he shall order that such person be admitted to and detained in a place of detention for such period not exceeding one year as the provincial judge may consider necessary.

(6) In any inquiry under this section, a certificate as to the result of any test made, signed or purporting to be signed by the director of a laboratory approved by the Minister is *prima facie* evidence of the facts stated therein and of the authority of the person giving such certificate without any proof of appointment or signature.

(7) Any person detained under this section may, with the approval in writing of the Minister, be brought before a provincial judge at any time during the last thirty days of the period for which he is so detained, and if the judge finds that he is still infected with venereal disease and in need of further treatment, he may order that such person be further detained for a period not exceeding one year as the judge may consider necessary.

(8) Where the Minister is of the opinion that any person detained under this section is no longer infected with venereal disease or has received an adequate degree of treatment, he may direct the discharge of such person. 1974(2nd), c.92, s.6.

7. (1) Where any physician in medical charge of any correctional institution, lock-up or training school, has reason to believe that any person under his charge may be infected with venereal disease or has been exposed to infection with venereal disease, he may, and if he is directed by the Chief Health Officer, he shall cause such person to undergo such examination as may be necessary to ascertain whether or not he is infected with venereal disease or to ascertain the extent of venereal disease infection, and if the examination discloses that he is so infected, the physician shall report the facts to the Chief Health Officer who may thereupon exercise the powers vested to him by section 9.

(2) Where an examination has not been made under this section, every physician in medical charge of any correctional institution, lock-up or training school, shall report to the Chief Health Officer the name and place of confinement of any person under his charge whom he suspects or believes to be infected with venereal disease and the report shall be made within twenty-four hours after he suspects or believes such person to be so infected.

(3) A copy or statement of every report made under this section shall be forwarded to the Minister and the Chief Health Officer by the physician making the report. 1974(2nd), c.92, s.7.

Order for
detentionLaboratory
certificate *prima
facie* evidenceExtension of
detentionDischarge by
MinisterExamination by
physician in
charge of
institutionDuty of
physician in
charge of
institution

Duplicate report

who has been examined by a physician at any time within one year previously and has been certified by such physician to be infected with syphilis.

(6) The Chief Health Officer may require a person who he believes may be infected with venereal disease to undergo more than one examination in order to determine the presence or absence of the infection. 1974(2nd).c.92,s.4.

5. (1) Where

(a) any person has been named under oath as a source or contact of venereal disease or is believed by the Chief Health Officer to be a source or contact of the venereal disease; and

(b) in the opinion of the Chief Health Officer the clinical findings and history of such person indicate that such person is or may be infected with venereal disease;

the Chief Health Officer may, whether or not laboratory findings indicate the presence of venereal disease, proceed in the manner prescribed in clauses 4(3)(a) and (b).

(2) For the purposes of subsection (1), the Chief Health Officer may administer an oath and take a statement under oath. 1974(2nd).c.92,s.5.

6. (1) The Chief Health Officer may make a complaint or lay an information in writing and under oath before a provincial judge charging that the circumstances set out in clause (5)(a) or (b) exist with regard to any person named in the complaint or information.

(2) Upon receiving a complaint or information, the provincial judge shall hear and consider the allegations of the complainant, and if he considers it desirable or necessary, the evidence of any witnesses, and if he is of the opinion that a case for so doing is made out, he shall issue a summons directed to the person complained of requiring the person complained of to appear before him at a time and place named therein.

(3) Where a person to whom a summons is directed does not appear at the time and place named therein or where it appears that a summons cannot be served, a provincial judge may issue a warrant directing that the person named in the summons be brought before him.

(4) Where a person appears or is brought before a provincial judge under this section, the judge shall inquire into the truth of the matters charged in the complaint or information and for such person shall proceed in the summary manner set forth in Part XXIV of the *Criminal Code* of Canada, R.S.C. 1970, Chap. C-34 and has all such powers as may be necessary to enable him to exercise that jurisdiction.

to report within twenty-four hours every case of venereal disease coming under his diagnosis, treatment, care or charge for the first time to the Chief Health Officer.

(2) Every person required to report a case of venereal disease under subsection (1) shall make the report in writing, by telephone, or in person to the Chief Health Officer. 1974(2nd), c.92, s.3.

4. (1) Where the Chief Health Officer has reasonable grounds for believing that a person is or may be infected with venereal disease or has been exposed to infection, the Chief Health Officer may give notice in writing in the prescribed form to such person directing him to submit to an examination by a physician designated by or satisfactory to the Chief Health Officer, and to procure and produce to the Chief Health Officer within the time specified in the notice, a report or certificate of the physician that such person is or is not infected with venereal disease.

(2) Every person who without reasonable excuse, the proof of which is upon him, fails to comply with a direction made under subsection (1) is guilty of an offence and liable to imprisonment for a term of not less than seven days and not more than twelve months.

(3) If by the report or certificate mentioned in subsection (1) it appears that the person so notified is infected with venereal disease, the Chief Health Officer may

(a) deliver to such person directions in the prescribed form as to the course of conduct to be pursued and may require such person to produce from time to time evidence satisfactory to the Chief Health Officer that he is undergoing adequate medical treatment and is in other respects carrying out such directions, and where such person fails to comply with the course of conduct prescribed for him or to produce the evidence required, the Chief Health Officer may exercise all the powers vested in him by clause (b) or may proceed under section 6; or

(b) with the approval of the Minister, order in writing that such person be removed and detained in a place of detention for the prescribed treatment until such time as the Chief Health Officer is satisfied that an adequate degree of treatment has been attained.

(4) Where the Chief Health Officer makes an order under clause (3)(b) he shall deliver the order to a peace officer who shall thereupon take the person named in the order into his custody and remove him to the place of detention named in the order, and the person for the time being in charge of the place of detention, upon receiving the order, shall receive such person and shall detain him until he is authorized by the Chief Health Officer to release him.

(5) The Chief Health Officer may adopt the procedure or do any of the acts referred to in subsection (3) with regard to any person



CHAPTER V-2

VENEREAL DISEASES PREVENTION ACT

1. In this Act

- (a) "Chief Health Officer" means the Chief Health Officer appointed under the *Public Health Act, R.S.P.E.I. 1974, Cap. P-29*;
- (b) "Minister" means the Minister of Health;
- (c) "physician" means a legally qualified medical practitioner;
- (d) "place of detention" means a hospital, sanatorium, correctional institution, lock-up, training school, or any place designated as a place of detention by the Lieutenant Governor in Council;
- (e) "prescribed" means prescribed by the regulations;
- (f) "regulations" means the regulations made under this Act or the *Public Health Act, R.S.P.E.I. 1974, Cap. P-29*;
- (g) "venereal disease" means syphilis, gonorrhoea, chancre, granuloma inguinale or lymphogranuloma venereum.
- 1974(2nd), c.92, s.1.

Definitions

2. (1) Every person infected with venereal disease upon becoming aware or suspecting that he is so infected shall place himself forthwith under the care and treatment of a physician.
- (2) Every person referred to in subsection (1) shall conduct himself in such a manner as not to expose other persons to the danger of infection, and shall take and continue treatment in a manner and to an extent considered to be adequate by the attending physician and the Minister. 1974(2nd), c.92, s.2.

Infected person to submit to treatment

Duty not to expose others to infection, treatment

Duty to report cases

3. (1) It is the duty of
- (a) every physician;
- (b) every superintendent or head of a hospital, sanatorium or laboratory; and
- (c) every person in medical charge of any correctional institution, lock-up, training school or college or other similar institution;

Ile-du-Prince-Edouard

(2) These amendments are consequential on the new offence proposed by subclause (1).

Clause 50: This amendment would recognize venereal disease to be a health problem rather than a crime.

Section 253 reads as follows:

"253. (1) Every one who, having venereal disease in a communicable form, communicates it to another person is guilty of an offence punishable on summary conviction.

(2) No person shall be convicted of an offence under this section where he proves that he had reasonable grounds to believe and did believe that he did not have venereal disease in a communicable form at the time the offence is alleged to have been committed.

(3) No person shall be convicted of an offence under this section upon the evidence of only one witness, unless the evidence of that witness is corroborated in a material particular by evidence that implicates the accused.

(4) For the purposes of this section, "venereal disease" means syphilis, gonorrhea or soft chancre."

Clause 51: This amendment would add the definition "credit card" taken from the present subsection 301.1(3) and, in the definition "document", would add the underlined words to make it clear that the definition "document" includes "credit cards".

Clause 52: These amendments, which would substitute the underlined amount for the amount of "two hundred dollars", are consequential on the amendment to section 483 proposed by clause 114.

(2). — Découlent de la nouvelle infraction créée au paragraphe (1).

Article 50. — Reconnaît le fait que les maladies vénériennes sont un problème de santé et non un crime.

Texte actuel de l'article 253 :

"253. (1) Est coupable d'une infraction punissable sur déclaration sommaire de culpabilité, quiconque, étant atteint d'une maladie vénérienne transmissible, la communique à une autre personne.

(2) Nul ne doit être déclaré coupable d'une infraction visée par le présent article s'il prouve qu'il avait raisonnablement lieu de croire, et croyait effectivement, qu'il n'était pas atteint d'une maladie vénérienne transmissible à l'époque ou l'infraction aurait été commise.

(3) Nul ne doit être déclaré coupable d'une infraction prévue au présent article sur la déposition d'un seul témoin, à moins que la déposition de ce témoin ne soit corroborée sous un rapport essentiel par une preuve qui implique le prévenu.

(4) Aux fins du présent article, l'expression «maladie vénérienne» signifie la syphilis, la gonorrhée ou le chancre mou.»

Article 51. — Adjunction de la définition de «carte de crédit» prise au paragraphe 301.1(3) actuel, et adjunction des mots soulignés à la définition de «document» pour établir clairement que la définition de «document» comprend les «cartes de crédit».

Article 52. — Substitution du montant souligné au montant de «deux cents dollars»; découle de la modification de l'article 483 proposée par l'article 114.

Punishment	<p>that the death of, or bodily harm to, the hostage will be caused or that the confinement, imprisonment or detention of the hostage will be continued</p> <p>with intent to induce any person, other than the hostage, or any group of persons or any state or international or intergovernmental organization to commit or cause to be committed any act or omission as a condition, whether express or implied, of the release of the hostage.</p>	<p>(2) Every one who takes a person hostage is guilty of an indictable offence and is liable to imprisonment for life.</p>	
Non-resistance	<p>(3) Subsection 247(3) applies to proceedings under this section as if the offence under this section were an offence under section 247."</p>	<p>(2) The said Act is further amended in the manner and to the extent set out in Schedule 20</p>	
I.	<p>50. Section 253 of the said Act is repealed.</p>	<p>50. L'article 253 de la même loi est abrogé.</p>	
Punishment	<p>(2) Quiconque se livre à une prise d'otage est coupable d'un acte criminel et est passible de l'emprisonnement à perpétuité.</p>	<p>(2) La même loi est en outre modifiée de la façon et dans la mesure exposées à l'annexe I.</p>	
Non-resistance	<p>(3) Le paragraphe 247(3) s'applique aux procédures intentées en vertu du présent article comme si l'infraction que ce dernier prévoit était celle que prévoit l'article 247.</p>	<p>(2) The said Act is further amended in the manner and to the extent set out in Schedule 20</p>	
I.	<p>50. Section 253 of the said Act is repealed.</p>	<p>50. L'article 253 de la même loi est abrogé.</p>	
Punishment	<p>(2) Quiconque se livre à une prise d'otage est coupable d'un acte criminel et est passible de l'emprisonnement à perpétuité.</p>	<p>(2) La même loi est en outre modifiée de la façon et dans la mesure exposées à l'annexe I.</p>	
Non-resistance	<p>(3) Le paragraphe 247(3) s'applique aux procédures intentées en vertu du présent article comme si l'infraction que ce dernier prévoit était celle que prévoit l'article 247.</p>	<p>(2) The said Act is further amended in the manner and to the extent set out in Schedule 20</p>	
I.	<p>50. Section 253 of the said Act is repealed.</p>	<p>50. L'article 253 de la même loi est abrogé.</p>	
Punishment	<p>(2) Quiconque se livre à une prise d'otage est coupable d'un acte criminel et est passible de l'emprisonnement à perpétuité.</p>	<p>(2) La même loi est en outre modifiée de la façon et dans la mesure exposées à l'annexe I.</p>	
Non-resistance	<p>(3) Le paragraphe 247(3) s'applique aux procédures intentées en vertu du présent article comme si l'infraction que ce dernier prévoit était celle que prévoit l'article 247.</p>	<p>(2) The said Act is further amended in the manner and to the extent set out in Schedule 20</p>	
I.	<p>50. Section 253 of the said Act is repealed.</p>	<p>50. L'article 253 de la même loi est abrogé.</p>	
Punishment	<p>(2) Quiconque se livre à une prise d'otage est coupable d'un acte criminel et est passible de l'emprisonnement à perpétuité.</p>	<p>(2) La même loi est en outre modifiée de la façon et dans la mesure exposées à l'annexe I.</p>	
Non-resistance	<p>(3) Le paragraphe 247(3) s'applique aux procédures intentées en vertu du présent article comme si l'infraction que ce dernier prévoit était celle que prévoit l'article 247.</p>	<p>(2) The said Act is further amended in the manner and to the extent set out in Schedule 20</p>	
I.	<p>50. Section 253 of the said Act is repealed.</p>	<p>50. L'article 253 de la même loi est abrogé.</p>	

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

"carte de crédit"

Non-resistance

Punishment

"document"

Maladie vénérienne - Article 253

Loi modifiant le Code criminel, 1919, c.46. Le Code criminel a été modifié par 1919, c.46, a.8 par l'insertion, immédiatement après l'article 316, de ce qui suit :

Communication de maladie vénérienne.

"316 A. (1) Est coupable de contravention et passible, sur conviction par voie sommaire, d'une amende n'excédant pas cinq cents dollars ou d'un emprisonnement ne dépassant pas six mois, ou des deux peines à la fois, quiconque souffre de maladie vénérienne communicable, et qui sciemment ou par négligence coupable communique cette maladie vénérienne à une autre personne.

"Toutefois, une personne ne doit pas être déclarée coupable de contravention en vertu du présent article, si qu'elle n'était pas atteinte de maladie vénérienne communicable, à l'époque de la prétendue contravention.

"Toutefois, de plus, nul ne doit être déclaré coupable de contravention, en vertu du présent article, sur le témoignage d'un seul témoin, à moins qu'une déposition impliquant l'accusé ne corrobore, dans quelque détail essentiel, le témoignage de ce témoin.

"(2) Pour les fins du présent article, l'expression "maladie vénérienne" signifie la syphilis, la gonorrhée ou le chancre mou."

Code criminel, S.R.C. 1927, c.36

L'article 316A devint l'article 307.

Code criminel, 1953-54, c.51

L'article 307 devint l'article 239 dont le libellé était celui qui est utilisé maintenant dans S.R.C. 1970, c.C-34, a.253

Code criminel, S.R.C., 1970, c.C-34

L'article 239 est devenu l'article 253.

Maladies vénériennes

Maladie vénérienne - Défense - Corroboration - "Maladie vénérienne".

253. (1) Est coupable d'une infraction punissable sur déclaration sommaire de culpabilité, quiconque, étant atteint d'une maladie vénérienne transmissible, la communique à une autre personne.

(2) Nul ne doit être déclaré coupable d'une infraction visée par le présent article s'il prouve qu'il avait raisonnablement lieu de croire, et croyait effectivement, qu'il n'était pas atteint d'une maladie vénérienne transmissible à l'époque où l'infraction aurait été commise.

(3) Nul ne doit être déclaré coupable d'une infraction prévue au présent article sur la déposition d'un seul témoin, à moins que la déposition de ce témoin ne soit corroborée sous un rapport essentiel par une preuve qui implique le prévenu.

(4) Aux fins du présent article, l'expression "maladie vénérienne" signifie la syphilis, la gonorrhée ou le chancre mou. 1953-54, c. 51, art. 239.

Historique. Anciennement 1953-54, c. 51, a. 239; 1927, c. 36, a. 307; 1906, c. 146, a. 316A [adopté par 1919, c. 46, a. 8].

Articles connexes. Code, art. 202-204 - Négligence criminelle; 720 - Définitions; 722 (1) - Peine générale; 722(3) - Époque du paiement; 722(4) - Facteurs à considérer; 722(5) - Facteurs à considérer; 722(6) - Mandat d'incarcération; 722(7) - Motifs d'incarcération; 722(8) - Si l'accusé se rend; 722(9) - Jeunes contrevenants; 722(10) - Prorogation du délai - 722(11) - "Amende"; 744 - Frais.

Lois connexes. Loi d'interprétation, S.R.C. 1970, c. I-23, a. 27.

253 (1) **Communication de maladies.** Ce texte a d'abord été adopté comme étant l'art. 316A en 1919. Avant cette époque, ce n'était pas une infraction de communiquer une maladie, y compris la maladie vénérienne : R. v. Clarence (1888), 22 Q.B.D. 23 (U.K. C.C.R.). Depuis l'adoption de cet article, qui exigeait en infraction le fait de communiquer ces maladies, il fut jugé que, si une maladie vénérienne communiquée par l'accusé entraînait la mort, il serait coupable d'homicide involontaire coupable : R. v. Leaf (1926), 45 C.C.C. 236 (C.A., Saskatchewan).

Code criminel du Canada

Suède

Loi N° 231 du 26 avril 1968 sur la lutte contre les maladies transmissibles (voir *Rec. int. Lég. sanit.*, 1969, 20, 160).

Arrêté royal N° 234 du 26 avril 1968 sur la lutte contre les maladies transmissibles (voir *ibid.*, 166).

Tunisie

Instruction N° 30 du 17 décembre 1968 du Ministère de la Santé fixant des mesures contre les maladies vénériennes (voir *Rec. int. Lég. sanit.*, 1969, 20, 572).

Loi N° 64-46 du 3 novembre 1964 portant institution d'un certificat pré-nuptial (voir *Rec. int. Lég. sanit.*, 1966, 17, 407).

Yougoslavie

Décret du 28 décembre 1973 portant promulgation de la Loi sur la protection de la population contre les maladies infectieuses qui menacent l'ensemble du pays (voir *Rec. int. Lég. sanit.*, 1974, 25, 915).

Suisse

Ordonnance du 17 juin 1974 sur la déclaration des maladies transmissibles de l'homme (article 5) (voir *Rec. int. Lég. sanit.*, 1975, 26, 217).

1972, 23, 435).

Circulaire du 9 septembre 1970 de la Direction nationale de la Santé publique et de la Prévoyance sociale prévoyant des mesures de lutte contre la blennorragie (voir *ibid.*,

- Israël**
Arrêté du 24 novembre 1960 sur la santé publique (maladies infectieuses) (voir *Rec. int. Lég. sanit.*, 1961, 12, 786).
- Italie**
Loi n° 837 du 25 juillet 1956 réformant la législation en vigueur sur la prophylaxie des maladies vénériennes (voir *Rec. int. Lég. sanit.*, 1957, 8, 503).
- Décret n° 2056 du Président de la République en date du 27 octobre 1962 portant exécution de la Loi n° 837 du 25 juillet 1956 réformant la législation en vigueur sur la prophylaxie des maladies vénériennes (voir *ibid.*, 1963, 14, 658).
- Luxembourg**
Loi du 19 décembre 1972 portant introduction d'un examen médical avant mariage et modification des articles 63, 75 et 109 du Code civil (voir *Rec. int. Lég. sanit.*, 1973, 24, 940).
- Règlement grand-ducal du 14 mars 1973 déterminant les examens à effectuer en vue de la délivrance du certificat médical avant mariage (voir *ibid.*, 941).
- Madagascar**
Décret n° 67-032 du 17 janvier 1967 déterminant les modalités de la lutte contre les maladies vénériennes (voir *Rec. int. Lég. sanit.*, 1968, 19, 194).
- Mexique**
Décret du 19 novembre 1969 fixant les conditions qui devront être remplies pour la délivrance du certificat médical pré-nuptial visé à l'article 90 du Code sanitaire des Etats-Unis du Mexique (voir *Rec. int. Lég. sanit.*, 1972, 23, 297).
- Nouvelle-Zélande**
Loi n° 65 du 25 octobre 1956 portant codification et amendement de la législation relative à la santé publique (voir *Rec. int. Lég. sanit.*, 1964, 15, 894).
- Décret n° 62-0317 M.S.A.S. du 16 août 1962 organisant la lutte contre les maladies vénériennes (voir *Rec. int. Lég. sanit.*, 1964, 15, 894).
- Roumanie**
Instruction n° XII/C1/2758 du 24 juillet 1971 concernant la prévention des maladies vénériennes et la lutte contre ces maladies (voir *Rec. int. Lég. sanit.*, 1972, 23, 406).
- Sénégal**
Décret n° 62-0317 M.S.A.S. du 16 août 1962 organisant la lutte contre les maladies vénériennes (voir *Rec. int. Lég. sanit.*, 1964, 15, 894).
- République démocratique allemande**
Ordonnance du 23 février 1961 sur la prévention des maladies vénériennes et la lutte antivénérienne (voir *Rec. int. Lég. sanit.*, 1962, 13, 623).
- République fédérale d'Allemagne**
Ordonnance du 20 février 1971 du Ministre de la Santé et de la Prévoyance sociale relative à la coopération des organes et institutions d'Etat et des organisations sociales dans le domaine de la lutte contre les maladies vénériennes (voir *ibid.*, 1973, 24, 399).
- Pologne**
Ordonnance n° 276 du Ministre de la Santé, en date du 29 août 1958, relative aux travaux dont l'exécution est interdite aux personnes atteintes de maladies vénériennes (voir *Rec. int. Lég. sanit.*, 1960, 11, 354).
- Ordonnance du 2 septembre 1964 du Ministre de la Santé et de la Prévoyance sociale relative aux examens médicaux en vue du dépistage des maladies vénériennes (voir *ibid.*, 1965, 16, 761).
- Ordonnance du 20 février 1971 du Ministre de la Santé et de la Prévoyance sociale relative à la coopération des organes et institutions d'Etat et des organisations sociales dans le domaine de la lutte contre les maladies vénériennes (voir *ibid.*, 1973, 24, 399).

N° 62-840 du 19 juillet 1962 relatif à la protection maternelle et infantile (voir *ibid.*, 1965, 16, 144).
Arrêté du 27 août 1971 du Ministère de la Santé publique et de la Sécurité sociale et du Secrétaire d'Etat à la Rétadaptation relatif aux examens médicaux pré et postnataux (voir *ibid.*, 1972, 23, 80).
Grèce

Loi N° 3310 du 13 juillet 1955 sur la lutte contre les maladies vénériennes et questions connexes (voir *Rec. int. Lég. sanit.*, 1958, 9, 526).

Guatemala
Décret N° 17-73 du 5 juillet 1973 portant Code pénal (voir *Rec. int. Lég. sanit.*, 1974, 25, 887).
Haute-Volta

Arrêté N° 71-46 SP.P.A.S. du 16 février 1971 du Ministère de la Santé publique, de la Population et des Affaires sociales fixant la liste des maladies à déclaration obligatoire ou facultative (voir *Rec. int. Lég. sanit.*, 1973, 24, 602).
Hongrie

Ordonnance N° 9 du 27 juin 1972 du Ministère de la Santé portant application des dispositions relatives à l'épidémiologie de la Loi II de 1972 sur la santé (voir *Rec. int. Lég. sanit.*, 1973, 24, 879).
Ordonnance N° 12 du 11 juillet 1972 du Ministère de la Santé relative à l'examen médical et à l'expertise de l'aptitude au travail (voir *ibid.*, 885).
Ordonnance N° 15 du 5 août 1972 du Ministère de la Santé portant application des dispositions relatives à l'assistance curative et préventive de la Loi II de 1972 sur la santé (voir *ibid.*, 888).

Circulaire du 28 juin 1973 de la Direction de la Santé publique sur la réglementation des médecins dans le domaine de la lutte contre les maladies vénériennes (voir *Rec. int. Lég. sanit.*, 1975, 26, 96).
Circulaire du 28 juin 1973 du Ministère de l'Intérieur concernant des directives pour l'organisation de la lutte contre les maladies vénériennes en vertu de la Loi N° 287 du 23 mai 1973 (voir *ibid.*).

Espagne
Décret du 4 juillet 1958 portant approbation du Règlement de la lutte contre la lèpre, les maladies vénériennes et les dermatoses (voir *Rec. int. Lég. sanit.*, 1959, 10, 297).

Etats-Unis d'Amérique
Loi du 2 mars 1959 modifiant l'article 6 du chapitre 1^{er} du titre 48 du Code de la Virginie occidentale de 1931, tel qu'il a été modifié, relatif aux demandes de licence de mariage (voir *Rec. int. Lég. sanit.*, 1962, 13, 134).

Fidji
Avis légal N° 85 du 16 juin 1961 portant règlement sur la pureté des denrées alimentaires (Règlement de 1961 sur la pureté des denrées alimentaires) (voir *Rec. int. Lég. sanit.*, 1964, 15, 397).
Ordonnance N° 10 du 21 mai 1964 sur la santé publique (modification) (voir *ibid.*, 1968, 19, 174).

France
Ordonnance N° 60-1246 du 25 novembre 1960 modifiant et complétant les dispositions du chapitre 1^{er} du titre II du livre III du Code de la Santé publique (voir *Rec. int. Lég. sanit.*, 1961, 12, 537).
Décret N° 64-931 du 3 septembre 1964 modifiant et complétant le Décret

- fiant la législation relative à la santé publique (Loi de 1962 sur la santé publique) (voir *Rec. int. Lég. sanit.*, 1965, 16, 32).
- Règlement du 24 mai 1966 sur la santé publique (maladies vénériennes) (voir *ibid.*, 1968, 19, 752).
- Loi N° 35 du 11 novembre 1966 portant modification de la Loi de 1962 sur la santé publique (Loi de 1966 sur la santé publique) (voir *ibid.*, 753).
- Brésil
- Décret N° 49.974-A du 21 janvier 1961 réglementant sous le nom de Code national de la Santé la Loi N° 2312 du 3 septembre 1954 portant normes générales pour la défense et la protection de la santé (voir *Rec. int. Lég. sanit.*, 1962, 13, 660).
- Bulgarie
- Décret N° 225 du 16 mars 1968 portant publication du Code de la Famille (voir *Rec. int. Lég. sanit.*, 1970, 21, 590).
- Arrêté N° 2247 du Ministère de la Santé publique et de la Prévoyance sociale relatif au certificat pré-nuptial de santé (voir *ibid.*).
- Résolution N° 23 du 23 mars 1974 du Conseil des Ministres portant approbation du Règlement d'application de la Loi sur la santé publique et de l'Ordonnance relative à la protection médico-sanitaire de la République populaire de Bulgarie contre les maladies quaranténaires et autres maladies contagieuses dangereuses (voir *ibid.*, 25, 543).
- Canada
- Alberta*
- Règlement de l'Alberta N° 492/61, en date du 28 décembre 1961, portant dispositions relatives à la lutte contre les maladies transmissibles (voir *Rec. int. Lég. sanit.*, 1962, 13, 697).
- Danemark
- Arrêté N° 21 du 22 janvier 1962 relatif à la lutte contre les maladies vénériennes au Groenland (voir *Rec. int. Lég. sanit.*, 1964, 15, 108).
- Loi N° 287 du 23 mai 1973 relative à la lutte contre les maladies vénériennes (voir *ibid.*, 1973, 24, 802).
- Cuba
- Décret ministériel (Santé publique) N° 7 du 16 mars 1962 portant règlement en matière de santé internationale et relatif aux services nationaux de santé (voir *Rec. int. Lég. sanit.*, 1963, 14, 35).
- Costa Rica
- Décret N° 4573 du 4 mai 1970 portant Code pénal (voir *Rec. int. Lég. sanit.*, 1975, 26, 65).
- Cuba
- Décret ministériel (Santé publique) N° 7 du 16 mars 1962 portant règlement en matière de santé internationale et relatif aux services nationaux de santé (voir *ibid.*, 1963, 14, 35).
- Colombie
- Décret N° 393 du 26 février 1963 édictant certaines règles relatives à la déclaration des maladies transmissibles (voir *Rec. int. Lég. sanit.*, 1964, 15, 104).
- Décret N° 239 du 10 février 1965 abrogeant le Décret N° 158 du 31 janvier 1964 et le remplaçant par d'autres dispositions portant application de l'article 66 du Décret-Loi N° 3224 de 1963 (voir *ibid.*, 1967, 18, 349).
- Costa Rica
- Décret N° 4573 du 4 mai 1970 portant Code pénal (voir *Rec. int. Lég. sanit.*, 1975, 26, 65).
- Cuba
- Décret ministériel (Santé publique) N° 7 du 16 mars 1962 portant règlement en matière de santé internationale et relatif aux services nationaux de santé (voir *ibid.*, 1963, 14, 35).
- Danemark
- Arrêté N° 21 du 22 janvier 1962 relatif à la lutte contre les maladies vénériennes au Groenland (voir *Rec. int. Lég. sanit.*, 1964, 15, 108).
- Loi N° 287 du 23 mai 1973 relative à la lutte contre les maladies vénériennes (voir *ibid.*, 1973, 24, 802).

Traité de lutte antivenérienne, Organisation mondiale de la santé, 1975

Législation

Allemagne (République fédérale d')

Loi du 25 août 1969 portant modification de la Loi sur la lutte contre les maladies vénériennes (voir Rec. Int. Lég. sanit., 1970, 21, 409).

Argentine

Loi N° 15.465 du 24 octobre 1960 rendant obligatoire, sur tout le territoire de la nation, la déclaration des cas de maladies infectieuses (voir Rec. int. Lég. sanit., 1961, 12, 716).

Australie

Nouvelle-Galles du Sud
Loi N° 37 du 15 octobre 1963 portant dispositions relatives à l'examen

Tasmanie

Loi N° 75 de 1962, publiée en date du 14 février 1963, codifiant et modifi-

médical des personnes atteintes ou présumées atteintes de maladie vénérienne, modifiant à cet effet et à d'autres fins la Loi de 1918 sur les maladies vénériennes ultérieurement modifiée et visant des fins connexes (Loi de 1963 sur les maladies vénériennes [modification]) (voir Rec. int. Lég. sanit., 1966, 17, 466).

Règlement du 5 juin 1964 portant application de la Loi de 1918 sur les maladies vénériennes, modifiée (voir *ibid.*, 1966, 17, 467).

Textes nationaux et
internationaux relatifs
aux maladies vénériennes

Annexe I

Willcox, R.R. Factors Leading to a Failure of Control of
Gonorrhoea, British Journal of Preventive Social Medicine,
vol. 16, 1962B, p. 113-122.

Willcox, R.R. Prostitution and Venereal Disease : Medical
'Control' of Prostitutes', Antiseptic, vol. 60, 1963, p.
6-14.

Wren, Barry, G. Gonorrhoea among Prostitutes, The Medical
Journal of Australia, vol. 5, 1967, 847-849.

- Romanowski, Barabara B. Sexually Transmitted Diseases : A Time for Action, Canadian Journal of Public Health, vol. 74, no. 3, 1983, p. 153-157.
- Romanowski, B., Meltzer, A.S., Rush, J. Treatment Guidelines for Selected Sexually Transmitted Diseases, Canadian Journal of Public Health, vol. 74, no. 3, 1983, p. 166-173.
- Ronald, A.R., et al. Research on Sexually Transmitted Diseases in Canada, Canadian Journal of Public Health, vol. 74, no. 3, 1983, 173-177.
- Rosenthal T., Vandon J. Prevalence of venereal disease in prostitutes, British Journal of Venereal Disease, vol. 34, 1958, p. 94-9.
- Rozovsky, L.E. and F.A. Legal Sex, Doubleday Canada Limited, Toronto, 1982.
- Sacks, S.L., Bowie, W.R., Stayner, M. Education and Public Awareness of Sexually Transmitted Diseases, Canadian Journal of Public Health, vol. 74, no. 3, 1983, p. 176-179.
- Santé et Bien-être social Canada. Maladies transmissibles sexuellement au Canada 1982, Bureau d'épidémiologie, Laboratoire de lutte contre la maladie. Direction générale de la protection de la santé, 1983.
- Santé et Bien-être social Canada. Rapport hebdomadaire des maladies au Canada, vol. 10-13, 31 mars 1984.
- Sgroi, Suzanne. Pediatric Gonorrhea and Child Sexual Abuse : The Venereal Disease Connection, Sexually Transmitted Diseases, July-September 1982, p. 154-156.
- Schofield, C.B.S. Sexually Transmitted Diseases, Churchill Livingstone, New York, 1979.
- Turner, B., Morton, R.S. Prostitution in Sheffield, British Journal of Venereal Disease, vol. 52, 1976, p. 197-203.
- Yorke, J.A., Hethcote, H.W., Nold, A. Dynamics and Control of the Transmission of Gonorrhea, Sexually Transmitted Diseases, vol. 5, 1978, p. 51-56.
- Willcox, R.R. Prostitution and Venereal Disease : Proportion of Venereal Disease Acquired from Prostitutes in Asia : A Comparison with France, the United Kingdom, and the United States of America, British Journal of Venereal Disease, vol. 38, 1962A, p. 37-42.

- Idsoe, O., and Guthrie, T. The Rise and Fall of the Treponematoses: Ecological Aspects and International Trends in Venereal Syphilis, British Journal of Venereal Disease, vol. 43, 1967, p. 227-243.
- Jessamine, A.G., Mathias, R., Sutherland, R. Epidemiology and Control of Sexually Transmitted Diseases, Canadian Journal of Public Health, vol. 74, no. 3, 1983, p. 163-166.
- Judson, F.N., et al. Comparative Prevalence Rates of Sexually Transmitted Diseases in Heterosexual and Homosexual Men, American Journal of Epidemiology, vol. 112, no. 6, 1980, p. 836-843.
- Keighley, Elizabeth. Venereal Disease among Women Prisoners, The Lancet, vol. 7, 1960, p. 253-254.
- King, Ambrose. Venereal Disease Problems and Adolescent Health, Clinical Pediatrics, vol. 5, 1966, p. 597-603.
- Knox, Samuel, R., Mandel, Bea, Lazarowicz, Remy. Profile of Callers to the VD National Hotline, Sexually Transmitted Diseases, October-December 1981, p. 245-254.
- Lentino, Walter. Medical Evaluation of a System of Legalized Prostitution, JAMA, vol. 158, 1955, p. 20-23.
- Meltzer, Alan S., Sexually Transmitted Diseases, Eden Press Incorporated, Westmount Québec and St. Albans, Vermont, 1981.
- Organisation mondiale de la santé, Lutte antivénéérienne : Aperçu de la législation récente, Genève, 1975.
- Pellegrin, M. Etude de la morbidité vénérienne dans les Alpes-Maritimes, La Prophylaxie sanitaire et morale, vol. 7, juillet 1966, p. 199-211.
- Post, J.B. A Foreign Office Survey of Venereal Disease and Prostitution Control, 1869-70, Medical History, vol. 22, 1978, 327-334.
- Potterat, J. et al. Gonorrhea in Street Prostitutes : Epidemiologic and Legal Implications, Sexually Transmitted Diseases, vol. 2, 1979, p. 58-63.
- Richards David. Sex, Drugs, Death, and the Law, Rowan and Littlefield, New Jersey, 1983.

BIBLIOGRAPHIE

- Adler, M.W. The terrible peril : a historical perspective on the venereal diseases, British Medical Journal, July, 19, 1980 p. 206-211.
- Catterall, R.D., and Nicol, C.S. Sexually Transmitted Diseases, Academic Press, London, 1976.
- Cini, Maltaise, Prostitution and Venereal Disease, 1983, (unpublished document).
- Conrad, G.L., et al. Sexually Transmitted Diseases among Prostitutes and Other Sexual Offenders, Sexually Transmitted Diseases, vol. 8, no. 4, 1981, p. 241-243.
- Darrow, William. Changes in Sexual Behavior and Venereal Diseases, Clinical Obstetrics & Gynecology, vol. 18, 1975, p. 255-267.
- Darrow, William. Approaches to the Problem of Venereal Disease Prevention, Preventive Medicine, vol. 5, 1976. p. 165-175.
- Darrow, William. Venereal Disease and Victimless Crime, Conference of the Society for the Study of Social Problems, 1978.
- Dunlop, E.M., Lamb, A.M., and King, D.M. Improved Tracing of Contacts of Heterosexual Men with Gonorrhoea, Relationship of altered female to male ratios, British Journal of Venereal Disease, vol. 47, 1971, p. 192-195.
- Evans, R.J. Prostitution, State and Society in Imperial Germany, Past & Present, vol. 70, 1976, p. 106-128.
- Hart, Gavin. Sexual Maladjustment and Disease : An Introduction to Modern Venereology, Nelson-Hall, Chicago, 1977.
- Holmes, King; Johnson, David; Trostle, Henry. An Estimate of the Risk of Men Acquiring Gonorrhea by Sexual Contact with Infected Females, American Journal of Epidemiology, vol. 91, no. 2, 1970, p. 170-174.
- Hooper, R.R., et al. Cohort Study of Venereal Disease : The Risk of Gonorrhea Transmission from Infected Women to Men, American Journal of Epidemiology, vol. 108, no. 2, p. 136-144.

Maladie vénérienne

Voir la définition de "maladies transmises sexuellement".

ment, Hooper ne révèle pas, contrairement à Darrow, quel est le risque de transmission en cas de relations sexuelles plus de trois fois. Comme certaines personnes se livrant à la prostitution auraient des relations sexuelles plus de trois fois par jour, les données fournies par Hooper ne nous disent pas si le risque de transmission s'accroît au-delà d'un certain nombre de fois.

Prostitués et prostituées

La plupart des études portant sur le rapport entre la prostitution et les MTS définissent la personne se livrant à la prostitution comme étant quelqu'un, habituellement une femme, qui livre son corps aux plaisirs sexuels d'autrui pour de l'argent.

Maladies transmises sexuellement

Cette expression a remplacé celle de "maladies vénériennes" dans les textes écrits. "Maladies vénériennes" s'entend habituellement des infections suivantes : la blennorrhagie, la syphilis, le chancre, le granulome inguinal et le lymphogranulome vénérien. Le terme "MTS" s'entend de ces infections ainsi que de l'urétrite non-gonococcique, de l'herpès génital, de la trichomonase, du SIDA, de la candidose, du molluscum contagieux, de la pédiculose (poux pubiens), de la gale (la "grattelle"), du condylome, de l'hépatite virale de type B, et des parasites intestinaux. Les MTS ne s'attrapent pas toutes par contacts sexuels. A titre d'exemple, une personne peut attraper des poux pubiens lorsqu'elle est mise en contact avec des draps infestés de poux. (Meltzer, 1981, p. 1)

Risque de transmission

Le risque de transmission s'entend de la probabilité d'attraper une MTS précise par contacts sexuels avec un partenaire contaminé. Les taux varient selon un certain nombre de facteurs tels que la race et le sexe. Hooper et d'autres chercheurs ont découvert un rapport important sur le plan statistique entre, d'une part, le risque de transmission de la blennorrhagie et, d'autre part, le nombre de partenaires et la fréquence des relations sexuelles. Selon les calculs, le risque de transmission chaque fois qu'il y a des rapports sexuels avec un partenaire contaminé était de .19 chez les hommes de race blanche et de .53 chez ceux de race noire.

communément le réservoir féminin d'infection) résulte, selon Hart, d'une simplification à outrance. Les preuves qui existent présentent souvent des symptômes que, chez l'homme, l'infection présente des symptômes peut être presque aussi importante.

Prévalence

Le nombre de cas d'une infection dans un milieu à un moment donné ou durant une période déterminée.

$$\text{PRÉVALENCE} = \text{INCIDENCE} \times \text{DURÉE DE LA MALADIE}$$

Etant donné le rapport existant entre l'incidence et la durée, la prévalence d'une maladie ne dépend pas seulement du nombre de nouveaux cas mais aussi de la durée de la maladie, de sorte que l'incidence peut être faible mais, s'il s'agit d'une maladie chronique, la prévalence peut être élevée. A titre d'exemple, dans le cas chez l'homme d'une blennorragie sans symptômes, il y a un taux d'incidence de 1 à 3 % et un taux de prévalence de 20 à 50 % (c'est-à-dire que la blennorragie ne présentant pas de symptômes constitue de 1 à 3 % de toutes les infections gonococciques chez l'homme, alors que, en tout temps, 20 à 50 % de toutes les infections gonococciques chez les hommes ne présentent pas de symptômes. (Hart, 1977)

Théorie de la promiscuité

Les personnes se livrant à la prostitution sont habituellement considérées comme une population à haut risque. Le bon sens semblerait indiquer que chez elles les probabilités d'attraper et de transmettre des MTS sont plus élevées que chez d'autres groupes, étant donné qu'en général elles ont des contacts avec un plus grand nombre de partenaires différents. L'hypothèse sous-jacente à la théorie de la promiscuité est que plus le nombre de partenaires sexuels est élevé au cours d'une période donnée, plus grand sera le risque de transmission de MTS. Il est possible que cette hypothèse ne tienne pas, car il a été démontré (Barrow, 1976) qu'il n'existe pas toujours un rapport direct entre le nombre de partenaires et celui des maladies vénériennes; aussi, n'est-elle pas concluante.

Hooper et d'autres chercheurs (1978) ont découvert un rapport important sur le plan statistique entre, d'une part, le risque de transmission de la blennorragie et, d'autre part, le nombre de partenaires et la fréquence des relations sexuelles chez les hommes. Malheureusement-

DEFINITIONS ET ANNOTATIONS

Antigène

Allergène; immunogène; toute substance qui, à la suite d'un contact avec les tissus appropriés d'un corps animal, entraîne un état de sensibilité ou de résistance à l'infection ou à des substances toxiques après une période de latence (de 8 à 14 jours) et lorsqu'elle réagit d'une façon perceptible avec les tissus ou les anticorps du sujet concerné. Tiré de [Traduction] : Stedman's Medical Dictionary, Fifth Edition, Anderson's Publishing Company, 1982.

Noyau

Ce concept pose en principe qu'il existe des groupes restreints de personnes qui, en raison de leurs caractéristiques sociodémographiques, de leurs styles de vie, de leurs activités sexuelles et de leur façon de prendre soin de leur santé, constituent des contaminants importants de MTS tant à l'intérieur qu'en dehors de leurs milieux sexuels immédiats. Cette hypothèse selon laquelle tous les cas d'une MTS déterminée peuvent être directement ou indirectement attribuables à ce noyau fait l'objet d'études. Potterat et d'autres chercheurs soulèvent l'hypothèse que les prostituées de Colorado Springs puissent constituer un groupe de ce genre. Il ne faudrait toutefois pas tenir comme établi que toutes les personnes se livrant à la prostitution sont des contaminants importants de MTS. Selon Yorke et d'autres chercheurs (1978), qui définissent le noyau comme étant constitué de groupes qui présentent une prévalence élevée (20 % ou plus) d'une maladie, tous les cas de blennorragie sont causés directement ou indirectement par le noyau de ce genre.

Epidémiologie

Etude de la prévalence et de la propagation de la maladie dans un milieu. Tiré de [Traduction] : Stedman's Medical Dictionary, Fifth Edition, Anderson's Publishing Company, 1982.

Groupe infecté

Ce groupe est constitué d'un ensemble varié de personnes, tant hommes que femmes, dont certaines présentent des symptômes et d'autres pas. L'idée d'un groupe de femmes ne présentant pas de symptômes (appelé

mes volontaires sont justifiés. L'établissement de
fiches de renseignements au nom des prostituées a été
écarté pour des motifs de droits de la personne. Les
lois sur les maladies vénériennes, du genre de celles
que nous avons au Canada, non seulement ne
semblent-elles pas moins efficaces que les mesures
volontaires de santé publique (Fotterat et autres,
1979), mais aussi elles soulèvent de graves questions
relativement aux droits de la personne. Nous en
arrivons donc à la conclusion que les seules mesures
qui peuvent se justifier tant pour des raisons
d'efficacité que pour des motifs concernant les droits
de la personne sont les programmes volontaires relatifs
aux MTS.

cette maladie qui ne se livrent pas à la prostitution peuvent continuer à se déplacer librement. Cela n'a-t-il pas pour effet de priver les prostituées, à titre de citoyennes d'un pays, de certains droits inaliénables relatifs à la personne? Ne s'agit-il pas seulement d'une discrimination à l'égard d'un groupe donné de personnes en raison de leur statut social "peu élevé"? De plus, l'argument fondé sur les droits de la personne soulève la question de l'égalité au sein de la société. Pourquoi la prostituée atteinte du SIDA devrait-elle posséder moins de droits que le client qui a contaminé la prostituée, ou moins de droits que les autres malades atteints du SIDA? Bref, les arguments fondés sur les droits de la personne soulignent la discrimination dont les prostituées sont victimes au nom de la "santé publique".

[Traduction] "Jeter le blâme sur quelqu'un d'autre, habituellement les femmes, pour la propagation des maladies vénériennes est un phénomène qui était déjà connu en Grande-Bretagne lorsque l'on faisait la chasse aux prostituées en recourant aux Contagious Disease Acts. Evidemment cette tradition s'était transmise avec succès à nos alliés des colonies et de l'Amérique du Nord, qui ne pouvaient concevoir que leurs fils ne soient pas vierges ou du moins les personnes innocentes." (Adler, 1980, p. 208)

Outre la question des droits de la personne, la théorie fondée sur l'utilitarisme perd du terrain, tout spécialement en ce qui concerne les programmes de traitements obligatoires ou les lois, pour la simple raison que ces mesures de contrôle ne sont pas particulièrement efficaces.

[Traduction] "On peut espérer que le fait d'accepter les prostituées comme étant des être humains et de porter intérêt à leurs besoins sur les plans physique et psychologique les amènera à collaborer davantage. On ne peut certes pas s'attendre à obtenir quelque résultat dans la solution de ce problème sans leur coopération." (Hart, 1977, p. 172)

Cela soulève la question de savoir pourquoi devrions-nous favoriser des mesures de contrôle obligatoires lorsqu'elles ne permettent pas d'atteindre des objectifs utiles (c'est-à-dire qu'elles ne protègent pas la santé publique) et lorsqu'elles vont à l'encontre des droits de la personne. Nous en venons à la conclusion que, de ces trois genres de mesures, seuls les programmes

Pour identifier les groupes à haut risque, il faudrait identifier leurs caractéristiques sociologiques (12) et le lieu où ils peuvent se trouver. Toutefois, les efforts en vue de lutter contre les MTS et portant sur des lieux particuliers, tels que les hôtels et les zones résidentielles, doivent être menés sans bouleverser la structure sociale sous-jacente du lieu ou de la région ni recourir à des mesures abusives qui ne serviraient qu'à faire fuir les gens contaminés.

Conclusions

On peut avoir recours à un grand nombre de mesures différentes pour lutter contre la propagation des MTS par les prostituées. Habituellement on invoquait des préoccupations utilitaires pour justifier l'obligation faite aux prostituées de se soumettre à des programmes concernant les maladies vénériennes. Selon cette théorie, ce qui est "utile" est "bon", et le point déterminant du "bon comportement" devrait être le caractère utile de ses conséquences. L'utilitarisme suppose que le but d'une action devrait être le plus grand excédent possible du plaisir sur la douleur ou le plus grand bonheur du plus grand nombre de gens. Dans ce cas tout particulièrement, on assume que la santé de la société en général est plus importante que les inconvénients qu'elle pourrait engendrer. Les examens médicaux obligatoires. Dans une récente émission de télévision ("Sixty Minutes", présentée au réseau C.B.S.), l'on a soutenu que l'arrestation et la détention d'une prostituée atteinte du SIDA étaient justifiées pour des motifs de santé publique malgré les problèmes économiques et personnels graves qu'il en résulterait pour la prostituée et les personnes à sa charge.

On peut s'opposer à ces arguments fondés sur l'utilitarisme en invoquant des arguments fondés sur les droits de la personne. Par exemple, on peut soutenir qu'il n'est pas équitable qu'une prostituée atteinte du SIDA soit emprisonnée, pendant que d'autres victimes de

12. Selon Hart (1979), il est important, lorsque l'on envisage des politiques de lutte contre les MTS, d'étudier chez les personnes des facteurs tels que la race, l'âge, la situation de famille, le degré d'instruction, le quotient intellectuel, le statut socio-économique, l'influence des parents, la consommation d'alcool et les mesures prises pour prévenir les MTS.

doivent se sentir libres de se présenter en tout temps pour un examen...". (Schofield, 1979, p. 28)

L'étude menée par Potterat (Potterat et autres, 1979) a montré de façon certaine que, de toutes les méthodes utilisées dans la lutte contre les MTS chez les prostituées, c'est le dépistage des contaminateurs possibles qui a permis de découvrir le plus de cas de blennorragie dans une clinique du Colorado.

c) Identification des groupes à haut risque

Selon Jessamine et d'autres chercheurs (1983), l'incidence accrue des infections gonococciques déclarées au Canada démontre que les programmes actuels de santé publique ne sont pas efficaces. Ils laissent entendre que la stratégie de base pour lutter contre ces maladies devrait être le dépistage des contaminateurs possibles, l'étude de cas et l'identification des partenaires sexuels considérés comme présentant le risque le plus élevé. En outre, ils laissent supposer qu'un système volontaire (11) pourrait également être adopté étant donné qu'il s'est révélé utile en Grande-Bretagne.

[Traduction] "Bien que les efforts actuels en matière de dépistage des contaminateurs possibles et d'étude de cas doivent se poursuivre, il faudrait consacrer des ressources supplémentaires à deux groupes. Il s'agit premièrement des personnes qui constituent le "noyau" directement ou indirectement responsable de chaque cas d'infection gonococcique survenant dans le milieu, et deuxièmement des cas, chez les hommes ne présentant pas de symptômes, d'infections qui existent depuis longtemps et sont maintenant étroitement identifiées aux infections pelviennes gonococciques de leurs partenaires sexuelles." (Jessamine et autres, 1983, p. 164)

11. On encourage les patients à en informer leurs partenaires réguliers et à les inciter à demander des soins médicaux.

Programmes de santé publique, dépistage des contaminants possibles et identification des groupes à haut risque

a) Programmes éducatifs

Il existe peu d'information sur l'efficacité des programmes éducatifs (Sacks et autres, 1983), tout particulièrement sur les programmes à l'intention des groupes à haut risque, tels que les prostituées. Toutefois, un certain nombre de spécialistes canadiens croient qu'il est important de donner plus d'information si l'on veut lutter plus efficacement contre les MTS.

[Traduction] "L'élaboration de programmes éducatifs sera essentielle dans la lutte contre les maladies transmises sexuellement. Ces programmes doivent viser à améliorer le traitement du client contaminé et avoir des répercussions positives sur le plan de la lutte contre ces maladies. En ce qui concerne l'éducation en matière de MTS dans notre pays, nous pensons que tous les programmes actuels d'éducation destinés aux différents groupes sont insuffisants. Cette conclusion se fonde non seulement sur notre opinion personnelle mais aussi sur l'opinion de plusieurs directeurs provinciaux chargés de la lutte contre les maladies vénériennes, qui ont répondu à un questionnaire que nous leur avons distribué." (Sacks, 1983, p. 176)

b) Dépistage des contaminants possibles

D'après Schofield (1979), l'efficacité du dépistage des contaminants possibles dépend du nombre de renseignements précis qui peuvent être obtenus du patient. C'est tout particulièrement important dans le cas des groupes, comme les prostituées, qui ont beaucoup de partenaires différents.

[Traduction] "Dans n'importe quelle région, le succès de la gestion médico-sociale des maladies transmises sexuellement dépend de la confiance que les gens de la région qui ont plusieurs partenaires, surtout ceux qui en ont beaucoup, montrent à l'égard du personnel de la clinique. Cette confiance met du temps à s'établir et peut se perdre rapidement si l'on ne s'occupe pas bien des patients. Il faut éviter de se montrer moralisateur, et ils

seulement de façon à convaincre le juge et le jury, mais hors de tout doute raisonnable."

A Atlanta, en Géorgie, sous le régime des Fulton County Health Regulations, toute personne arrêtée pour prostitution ou toute autre infraction de nature sexuelle est soupçonnée d'être atteinte d'une maladie transmise sexuellement et doit se rendre au Fulton County Health Department pour s'y soumettre à un examen médical.

Conrad et d'autres chercheurs (1981) ont étudié les dossiers médicaux des personnes appréhendées en vertu de ce règlement et en sont venus à la conclusion que l'examen et l'interrogatoire des auteurs d'infractions sexuelles constituent des moyens efficaces de dépister les cas de maladie transmise sexuellement qui n'ont pas été traités. (Conrad, 1981, p. 244)

Toutefois, Conrad n'est pas allé jusqu'à recommander l'adoption de programmes obligatoires ou de lois en ce sens.

Au Colorado, les fonctionnaires municipaux, de comté ou de l'Etat peuvent garder en détention les personnes soupçonnées d'avoir une maladie vénérienne et les faire examiner. La prostituée en état d'arrestation est détenue sans possibilité d'obtenir un cautionnement, jusqu'à ce qu'un fonctionnaire de la santé publique puisse se prononcer sur l'existence possible d'une maladie vénérienne. Potterat et d'autres chercheurs (1979) ont étudié ces mesures de contrôle et les ont comparées aux programmes volontaires. Ils ont découvert que les mesures obligatoires telles que les ordonnances judiciaires étaient beaucoup moins efficaces pour dépister les cas de blennorragie chez les prostituées que ne l'étaient les examens de routine subis par les prostituées dans une clinique ou le dépistage des contaminateurs possibles.

TABLEAU VII : Taux de blennorragie chez les prostituées établis en fonction de la fréquentation d'une clinique antivenérienne

Anciennes prostituées		Prostituées actives	
Raison de l'examen en clinique			
Nombre	%	Nombre	%
127/444	29	62/198	31
Examen de routine			
37/203	18	17/79	22
Ordonnance judiciaire			
62/135	46	32/61	52
Contact avec la blennorragie			
12/116	10	6/61	10
Suivi			
247/910	27	125/402	31
Total			
Tiré de Poterat et autres, 1979.			

Tiré de Potterat et autres, 1979.

de permis étiquette les femmes et leur rend plus difficile le retour à un métier plus "respectable" après qu'elles ont abandonné la prostitution. (Hart, 1977, p. 59).

[Traduction] "L'intérêt croissant à l'égard de la présumée "traite des blanches" a amené la Société des Nations et ensuite les Nations Unies à demander l'abolition des bordels sous licence, qui étaient considérés comme la principale source de la demande régulière en ce qui concerne le commerce international des femmes et des jeunes filles. Par suite des conventions internationales en la matière, ainsi que des revendications des féministes contre le fait que le système de permis réglementait et flétrissait indûment la vie des prostituées, les pays d'Europe l'ont abolie." (Richards, 1983, p. 91)

Lois autorisant l'arrestation et l'examen obligatoire des prostituées et autres personnes soupçonnées d'être atteintes d'une maladie vénérienne

Il existe un certain nombre d'exemples en ce domaine : le Criminal Justice Act de 1948 au Royaume-Uni, l'article 54-121 des Fulton County Health Regulations (Géorgie, E.-U.), l'article 25-4-404 des G.S. modifiés des Colorado Revised Statutes, et toutes les lois provinciales et territoriales au Canada sur les maladies vénériennes.

En Angleterre, sous le régime du Criminal Justice Act de 1948, il était possible d'envoyer une femme en détention provisoire dans une prison en attendant un rapport sur sa santé physique et mentale si elle était accusée d'une infraction punissable d'emprisonnement.

Au Canada, les provinces et les territoires ont chacun une loi qui oblige les gens à se faire examiner en cas de maladie vénérienne. Pour ce faire, les fonctionnaires oeuvrant dans le domaine de la santé publique se sont vu accorder de nombreux pouvoirs. Selon Rozovsky (1982, p. 71), cette procédure entraîne la privation de certains droits dont jouissent même ceux qui sont accusés d'infractions criminelles graves.

[Traduction] "Dans les poursuites criminelles, c'est au procureur de la Couronne qu'il incombe de prouver le bien-fondé de l'acte d'accusation, non

La police tenait un fichier de la prostitution et vérifiaient les dossiers médicaux et escortaient toute personne qu'ils soupçonnaient d'avoir attrapé une maladie vénérienne d'une prostituée.

Lentino faisait remarquer que cette méthode n'était pas efficace en raison de la difficulté à diagnostiquer les maladies vénériennes chez les femmes. Il signalait que, chez les soldats, 80 % des maladies vénériennes avaient été contractées dans des bordels possédant un permis. D'autres études concluaient également à l'inefficacité de ce genre de système, habituellement pour les raisons suivantes : il ne permet pas d'exercer un contrôle sur les personnes qui se livrent à la prostitution clandestinement; les examens médicaux fréquents peuvent donner une fausse impression de sécurité aux prostituées, aux clients et à ceux qui sont chargés d'exercer un contrôle; la tenue d'examens médicaux fréquents peut engendrer de l'hostilité chez les prostituées et restreindre leur collaboration; un système de ce genre corrompt presque inévitablement ceux qui sont chargés de sa supervision (Hart, 1977, p. 59-61); et les normes régissant l'examen médical obligatoire se modifient et tendent à se relâcher avec le temps (10).

En plus de l'inefficacité de cette méthode, que laissent supposer les données empiriques, il y a un autre inconvénient : les répétitions en matière de droits de la personne. On s'est opposé à l'inscription au fichier de la prostitution pour le motif que cela allait à l'encontre des droits civils de l'individu ainsi que de la conception moderne de la dignité humaine (Article 6 de la Résolution de 1950 des Nations Unies sur la prostitution). Ce mécanisme d'attribution

10. [Traduction] "Il a été démontré que les avantages découlant des examens médicaux de routine effectués régulièrement chez les prostituées ne sont obtenus qu'à un prix élevé. Même lorsqu'elle est bien appliquée, cette méthode ne serait pas économiquement tenable des résultats obtenus... Par ailleurs, en ce qui concerne les patientes atteintes de blennorragie, on a fait remarquer que les prostituées représentent une part importante du réservoir d'infection, et qu'il est logique de déployer un certain effort pour en réduire les proportions. Le véritable problème reste encore de déterminer comment en arriver à un juste équilibre." (Willcox, 1963, p. 8)

La lutte contre les MTS chez les personnes se livrant à la prostitution vise principalement à réduire le risque de transmission de ces maladies à leurs clients. Par le passé, on a eu recours à un certain nombre de solutions qui tombent habituellement dans l'une de ces trois principales catégories :

- inscription au fichier de la prostitution, et habituellement obligation de se soumettre à des examens médicaux;
- lois permettant l'arrestation et le traitement obligatoire des prostituées et prostituées soupçonnées d'être atteintes d'une maladie vénérienne;
- et programmes volontaires sous la direction de cliniques antivénériennes locales, qui ne visent pas particulièrement une clientèle se livrant à la prostitution mais tiendraient compte des besoins particuliers du prostitué et de la prostituée et s'occuperaient de dépister les contaminés possibles et d'identifier et de traiter les groupes à haut risque.

Nous étudierons successivement chacune de ces solutions et essaierons d'évaluer l'efficacité qui leur est attribuée.

Inscription au fichier de la prostitution et obligation de se soumettre à des examens médicaux

Un exemple typique de ce système est le bordel italien que décrit Lentino (Lentino, 1955). Le genre de système qu'il a examiné consistait en un établissement possédant un permis ainsi qu'une salle pour les examens médicaux. Des affiches étaient apposées aux murs afin d'informer tous les clients sur la prévention des maladies vénériennes. Tous les quinze jours, l'on procédait à un examen sérologique du sang pour la syphilis, et tous les deux jours à un examen médical pour la blennorragie. Lorsqu'une femme était atteinte d'une maladie vénérienne, elle était traitée et ne pouvait pas travailler tant qu'elle n'était pas complètement rétablie.

d) Absence de critères en vue de déterminer l'importance du problème

Ces études soulèvent un autre problème du fait que les critères auxquels elles font appel pour démontrer ou réfuter leurs hypothèses ne sont jamais définis clairement ni défendus. A titre d'exemple, aucune des études favorisant le "oui" n'établit que le taux d'infection devrait être déterminé avant que l'on puisse conclure que la prostitution ne contribue plus de façon importante à la propagation des MTS. Les études favorisant le "non" ne sont pas claires non plus sur ce point. Toutefois, les études favorisant le "non" donnent au moins une idée de la mesure dans laquelle les prostituées contaminées, comparativement aux autres groupes, continuent à leur tour leurs clients. Il faudrait cependant apporter encore des précisions, car l'étude de Turner et Morton (1976), qui a découvert que 17 % des cas de blennorragie chez les hommes pouvaient être reliés à la prostitution, a signalé que les prostituées contribuaient grandement à transmettre la blennorragie alors que le British Co-operative Clinical Group (Willcox, 1962B), faisait observer l'existence de taux plus élevés mais concluait toutefois que la prostitution ne contribuait pas de façon importante à ce problème.

Conclusions

- Après nous être penchés sur ces études, nous en sommes arrivés aux conclusions suivantes :
- toutes ces études recèlent des faiblesses sur le plan méthodologique;
 - Les prostituées ne contribuent pas à la propagation de la blennorragie de façon aussi importante que les autres femmes;
 - nous ne savons pas dans quelle mesure les prostituées contribuent à la propagation des MTS comparativement aux autres groupes à haut risque, comme les hommes de 20 à 24 ans;
 - dans certaines villes de l'Ouest, les péricatéticiennes constituent probablement un groupe à haut risque, car elles tendent à présenter un taux plus élevé de prévalence de la blennorragie que les autres femmes.

clients. La seule exception est l'étude menée par Turner et Morton (1976), qui a essayé d'établir un lien entre les prostituées et les taux d'infection chez leurs clients.

En outre, toutes ces études, qu'elles concluent à l'affirmative ou à la négative, s'intéressent aux prostituées et aux femmes définies comme "non prostituées". On n'y compare pas le rôle joué par les hommes dans la propagation des MTS à celui joué par les prostituées dans ce domaine. Cela constitue une faiblesse grave sur le plan logique, car les hommes et les femmes, qu'ils soient définis ou non comme étant des prostituées ou des prostituées, peuvent transmettre des MTS. Comme il a déjà été mentionné, les données officielles sur les MTS provenant du Canada, des Etats-Unis et de la Grande-Bretagne révèlent que les hommes âgés de 20 à 24 ans présentent de loin l'incidence la plus élevée de MTS. S'ils présentent l'incidence la plus élevée de MTS, ils doivent également être le groupe qui contribue le plus à la propagation des MTS au Canada et dans les autres pays. Ainsi que le fait remarquer Rosenthal, la plupart des études portent sur la prostitution parce que c'est plus facile ainsi, et non pas parce que c'est la chose la plus logique à faire :

[Traduction] "Cela signifie-t-il que les

prostituées doivent être d'importants

transmetteurs dans tous les domaines? La

réponse est non. Dans le cas de l'infection

pelvienne gonococcique, la prostitution joue

un rôle important. Le message est clair en ce

qui concerne les programmes de lutte contre la

blennorragie : bien regarder, même si la

lumière n'est pas très bonne. S'occuper des

femmes atteintes d'infection pelvienne, des

prostituées, des jeunes recrues militaires, de

la clientèle particulière d'un médecin privé,

de certains groupes d'homosexuels, des person-

nes provenant d'une région géographique

donnée." (Rosenthal et Vando, 1958,

p. 94-99.)

Par conséquent, le fait de ne pas évaluer dans quelle mesure d'autres groupes à haut risque contribuent à la propagation des MTS et de ne pas établir de comparaison avec le rôle que jouent les prostituées en ce domaine soulève un doute important quant à l'objectivité de toutes ces études, qu'elles favorisent une réponse affirmative ou une réponse négative à cette question.

Pour un examen de routine.) Cela signifie que les différences observées par Potterat dans les taux d'infection chez ces deux groupes pourraient simplement être dues au fait que ceux-ci ne se rendaient pas à la clinique suivant la même fréquence et non pas à la différence réelle dans les probabilités d'attraper et de transmettre des MTS.

Si on évalue ces études quant à l'effort tenté pour écarter ce qui pourrait empêcher d'en arriver à une conclusion valable en ce qui concerne les prostituées en général, on se rend compte que ces études présentent de graves lacunes, même sur les points les plus fondamentaux. A titre d'exemple, la plupart ne vérifient pas le sexe, l'âge, la race, le risque de transmission, la prévalence des MTS chez les partenaires ainsi que le genre de prophylactiques utilisés. Cela signifie que les différences observées entre les prostituées et les non prostituées peuvent résulter simplement de différences dans ces facteurs et non pas des activités sexuelles reliées à la prostitution.

c) Faiblesse du raisonnement logique et manque d'objectivité

L'un des résultats assez surprenants est que la plupart des études qui adoptent la position selon laquelle la prostitution contribue de façon importante à la propagation des MTS font appel à une méthode d'évaluation différente de celle qu'utilisent les études qui adoptent la position contraire. Les premières mesurent le taux d'infection d'un groupe particulier de prostituées, mais elles ne font pas le raisonnement logique qu'adopte le dernier groupe d'études. Elles n'essaient pas de quantifier dans quelle mesure ces prostituées contaminées continuent à leur tour leurs clients, par comparaison à l'effet que peuvent avoir en général les femmes contaminées sur le taux d'infection chez les hommes. Les études qui concluent à la négative montrent clairement que, au moins chez les prostituées étudiées, environ une infection sur cinq a été transmise par des prostituées alors que les quatre autres ont été transmises par d'autres groupes (c'est-à-dire des personnes rencontrées fortuitement, des amis, l'époux et des homosexuels).

Les études qui concluent à l'affirmative révèlent donc des faiblesses importantes sur le plan du raisonnement logique -- elles ne recueillent pas le genre de données qui leur permettraient de conclure que la prostitution contribue de façon importante à transmettre des MTS aux

fréquence des examens médicaux subis, de leur qualité et de l'efficacité des soins donnés, autant que du nombre de contacts qu'elles ont eus sans être protégées, de la prévalence de la maladie chez leurs partenaires, et des taux de transmission de la maladie par les personnes atteintes à celles qui sont susceptibles de l'attraper." (Conrad et autres, 1981, p. 242)

A titre d'exemple, Potterat et d'autres chercheurs (1979) ont comparé la fréquence des MTS chez un groupe de prostituées et chez un groupe de femmes qui ne se livraient pas à la prostitution. Ils tentaient de prouver que les prostituées seraient davantage susceptibles d'être contaminées que les femmes qui n'étaient pas des prostituées. Potterat prit soin de déterminer la race et l'âge de chacune des personnes composant ces groupes. Bien que ceux-ci étaient identiques quant à l'âge, ils ne l'étaient pas quant à la race des personnes qui les composaient. Vu que la probabilité d'attraper une MTS dépend de la race de la personne (Cooper et autres, 1978), Potterat aurait dû tenir compte de ce facteur au moment d'interpréter les résultats de son étude. Comme il n'a pas examiné ce facteur, ses résultats sont douteux, car toute différence du taux d'infection de ces deux groupes pourrait résulter non de leurs moeurs sexuelles mais plutôt des différences raciales.

La plupart des études mentionnées ci-dessus ne tiennent pas compte du fait que la prévalence ou l'incidence d'une maladie dépend du nombre de fois qu'une personne est examinée et traitée pour cette maladie. Plus l'examen et la procédure de déclaration seront valables, plus l'incidence enregistrée d'une maladie sera élevée. Les prostituées qui se présentent régulièrement à une clinique antivenérienne et se font traiter pour une MTS peuvent déclarer un taux plus élevé d'incidence de la maladie, car il peut survenir une nouvelle infection. Toutefois, si une personne n'est pas traitée pour la maladie, il n'y a pas de risque d'infection, car elle est déjà contaminée. Par exemple, l'étude menée par Potterat signale qu'en moyenne, les prostituées se soumettent à un plus grand nombre d'examen de routine dans une clinique antivenérienne de leur ville que ne le font les personnes du groupe de non-prostituées auxquelles elles étaient comparées! (31 % des femmes qui se livraient alors à la prostitution déclaraient s'être présentées à la clinique antivenérienne pour un examen de routine alors que seulement 11 % du groupe composé de femmes qui n'étaient pas des prostituées allaient à la clinique

probabilités pour chacune d'attraper des MTS et de les transmettre ne soient pas les mêmes. L'on ne peut pas étudier les péripatéticiennes et utiliser par la suite les résultats obtenus afin de tirer des conclusions s'appliquant aux prostituées en général.

Il ressort d'un examen du premier tableau (résumé des études favorisant le "oui") que la plupart de ces études ne portent pas sur un groupe de prostituées qui soient représentatives de toutes les prostituées. La plupart des études portent sur les péripatéticiennes. Les données sont donc considérablement biaisées -- il est très probable qu'on surestime la prévalence de la maladie pour l'ensemble des prostituées étant donné l'opinion selon laquelle les péripatéticiennes ont tendance à présenter un taux d'infection plus élevé que les prostituées des "classes plus élevées".

En outre, ces études portent sur un groupe de prostituées vivant dans un milieu bien déterminé -- habituellement en prison ou dans une ville comme Londres. Vu la croyance selon laquelle les MTS ont une prévalence plus élevée dans les grandes villes, plus particulièrement les villes portuaires, que dans les villes de moindre importance, ces études tendraient encore une fois à surestimer les taux d'infection.

En conclusion, ces études portent sur une catégorie précise de prostituées, vivant dans un milieu particulier et à une époque bien déterminée. Les résultats de ces études ne devraient pas servir à tirer des conclusions sur les prostituées en général, tout particulièrement lorsque le genre de prostituées et le milieu étudiés tendent à surestimer l'incidence des MTS.

b) Défaut de vérifier les facteurs qui influent sur les taux d'infection

Les chercheurs qui prévoient devoir étudier l'effet d'un facteur, tel qu'une maladie, sur un groupe particulier de personnes doivent essayer de vérifier tous les facteurs qui peuvent biaiser leurs résultats, comme l'âge, le sexe, l'occupation, le genre de protection utilisée afin d'éviter les MTS, etc. Ils définiront d'abord tous les facteurs qui peuvent biaiser leurs résultats et essaieront ensuite d'écarter tout ce qui risque de fausser les résultats, en faisant appel à diverses méthodes.

[Traduction] "Dans toute région géographique, le nombre de prostituées susceptibles d'être atteintes de blennorragie dépend de la

Le tableau qui suit résume les études de ce groupe.
TABLEAU VI : Résumé des études favorisant le "non"

Type de prostituées	Endroit	Groupe de comparaison; autres mesures de contrôle?	Période concernée	% de MTS rencontrées chez les prostituées
Willcox 1962A 1962B*	Royaume-Uni	oui	1962	15-19 %
1954	régions urbaines et rurales d'Angleterre et du pays de Galles	oui	1960	30 %
Dunlop et autres, 1971	Londres	oui	1969	31 %
Rosen-thal et autres, 1958	New York	oui	1946	23.6 % (B)
(*) A partir des données rassemblées par le British Clinical Co-operative Group. (B) signifie "biennorragie"				

Problèmes de méthodologie

a) Mauvaise utilisation de la "méthode inductive"

Toutes ces études font appel à la méthode inductive. Les recherches portent sur un petit groupe d'individus, et les résultats sont ensuite étendus à un groupe plus vaste, que ses membres fassent partie ou non du groupe sur lequel portent les recherches. Le problème le plus important que pose cette méthode est que, si l'on doit étendre les résultats obtenus aux prostituées, il faut que le groupe de prostituées que l'on étudie soit représentatif de toutes les prostituées. A titre d'exemple, la prostituée qui fait le trottoir, celle qui reçoit ses clients dans un bordel et celle qu'on appelle par téléphone couvrent un large éventail de personnes différentes. Il est possible que les

- La prostitution n'est plus un facteur important de propagation des MTS; le problème est aujourd'hui la promiscuité;

[Traduction] "Il y a plusieurs années, elles constituaient un foyer d'infection de toute première importance. De nos jours, cependant, le milieu de la prostitution fait face à une forte baisse des affaires sauf dans certains endroits comme les grandes villes et près des camps militaires, particulièrement ceux d'outre-mer. La concurrence de la part des non-professionnelles et des para-professionnelles se fait durement sentir du côté des prostituées professionnelles. À tel point qu'on estime que seulement 5 à 10 % des nouveaux cas de MTS sont transmis par les prostituées." (Dr Neumann, 1983, p. 155).

- Les études qui prétendent que la prostitution contribue de façon significative à la propagation des MTS font appel à des méthodes inadéquates (9). La meilleure façon de régler cette controverse est de déterminer si les études qui favorisent le "oui" sont assez solides, sur le plan méthodologique, pour justifier une conclusion de ce genre. Sinon, ces auteurs ne disposent pas des données leur permettant d'en arriver à une conclusion sur la question de savoir si la prostitution contribue ou non de façon significative à la propagation des MTS.

9. Selon Willcox (1962A, p. 37), [Traduction] "Il n'existe pas d'études assez objectives pour déterminer le rôle que jouent dans la propagation des maladies vénériennes les prostituées comparativement aux femmes de classes sociales inférieures qui ne sont pas des prostituées. Il est impossible d'y arriver tant que l'on ne pourra pas établir de rapports, premièrement, entre le nombre total de personnes de chacune de ces deux catégories et la population masculine à risque et, deuxièmement, entre les cas de maladie vénérienne et le nombre de contacts."

TABLEAU V : Résumé des études favorisant le "oui"

Etude	Type de prostituées et de prostituées	Endroit	Groupe de comparaison; autres mesures de contrôle?	Période de temps concernée	Pourcentage de MTS Prosti- tues et Autres
Wren 1967	Détenus	Prison d'Etat de la Nouvelle- Galles du Sud	Autres détenus; oui	Jan.- Juin 1966	(B) 44 % (S) 2 % 4 % 1 %
Keighley 1960	Prison d'Holloway	Londres	Autres détenus; oui, l'âge.	1958	(B) 34 % 4 %
Conrad et autres 1981	Auteurs d'infrac- tions sexuelles Prostituées et prosti- tues	Atlanta, Géorgie	Non	Sept.- Déc. 1978	(MTS hommes) 44.1 % (MTS femmes) 29.3 % (B) 28.3 %
Potterat et autres 1979	Prostituées fréquantant une clinique antivéné- rienne	Comté de Fresno	Non	1976-1977	(B) 19.8 %
Turner et autres	Prostituées	Sheffield, Angleterre	1958-1977	1960-1973	(B) 29 % 21 %
B signifie "blennorragie" S signifie "sypillis" MTS signifie "maladies transmises sexuellement"					

Les partisans du "non"

Les scientifiques qui ne sont pas d'accord avec cette première théorie (Hart, 1977; Darrow, 1976; Willcox, 1963; Neumann, 1983; Dunlop et autres, 1971; et Rosenthal, 1958) s'appuient sur les arguments suivants :

III. PROSTITUTION ET MTS : RECHERCHES EFFECTUEES AUX ETATS-UNIS ET AU ROYAUME-UNI

Les partisans du "oui"

Un certain nombre d'auteurs affirment que la prostitution contribue de façon significative à la propagation des maladies vénériennes (Conrad et autres, 1981; E.B. Turner et R.S. Morton, 1976; G.G. Frosner et autres, 1975; D. Fanta et autres, 1979; Z. Seliborska et autres, 1979; Idsoe et Guthe, 1967; Keighley, 1960; et Potterat et autres, 1979). A titre d'exemple, Conrad et d'autres (1981, p. 241) écrivent ce qui suit dans un article récent :

[Traduction] "Après avoir passé en revue toutes les études publiées sur le sujet que nous avons pu trouver et après avoir effectué une étude rétrospective des auteurs d'infractions sexuelles dans la ville d'Atlanta, nous ne pouvons qu'être en désaccord avec Rosenthal et Vadow. Nous croyons que dans certaines régions des Etats-Unis, tout comme ailleurs dans le monde, les personnes s'adonnant à la prostitution sont encore d'importants transmetteurs de la blennorragie et autres maladies transmises sexuellement."

Bien que les auteurs reconnaissent que la prostitution ne contribue pas à la propagation des MTS d'une manière aussi importante qu'on l'a déjà soutenu, ils croient que le changement n'est que relatif :

[Traduction] "Sur le plan épidémiologique, nos conclusions démontrent que le rôle de vecteur joué par la prostitution n'a pas diminué. La prétendue diminution de son rôle n'est que relative, et non pas réelle. La prostitution est responsable d'un cas sur six d'infection gonococcique contractée localement par les hommes hétérosexuels." (Turner et Morton, 1976, p. 52)

Le tableau suivant résume les résultats des études entreprises par les scientifiques qui adoptent cette position.

TABLEAU IV ROYAUME-UNI

Veneral diseases—new cases per 100 000 population by age seen at hospital clinics in England 1976-80

	1976			1977			1978			1979			1980		
	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total
Early syphilis															
All ages	8.86	1.50	5.08	9.67	1.71	5.59	10.27	1.91	5.98	10.77	1.77	6.16	9.54	1.59	5.46
Primary and secondary only	6.40	0.87	3.56	6.58	1.04	3.74	6.69	1.04	3.79	6.38	0.08	3.52	5.94	0.87	3.14
Under 16 years	0.07	0.09	0.08	0.04*	0.04	0.04	0.20	0.10	1.15	0.05	0.04	0.05	0.08	0.08	0.04
16-19 years	7.52	3.30	5.46	5.72	4.56	5.15	6.8	4.52	5.69	4.99	2.90	3.97	3.95	3.52	3.74
20-24 years	19.35	3.46	11.58	17.76	5.02	11.56	19.10	4.76	12.10	16.83	3.44	10.29	15.00	3.44	9.34
25 years and over	7.40	0.68	3.85	8.01	0.66	4.13	7.77	0.66	4.02	7.79	0.60	3.99	7.38	0.62	3.82
Late syphilis															
All ages	3.87	1.76	2.79	3.67	1.70	2.66	4.38	1.89	3.10	4.44	1.97	3.17	4.24	1.85	3.02
Congenital syphilis															
All ages	0.28	0.33	0.30	0.25	0.37	0.31	0.23	0.45	0.34	0.17	0.34	0.26	0.24	0.28	0.26
Gonorrhoea (post pubertal)															
All ages	161.91	89.60	125.79	164.70	92.23	127.54	161.38	89.94	124.73	154.67	85.84	119.36	155.40	86.64	120.14
Under 16 years	1.87	8.57	5.13	1.98	8.52	5.16	2.56	7.76	5.09	1.75	5.99	3.82	1.43	6.13	3.72
16-19 years	311.52	513.05	420.19	329.41	510.53	417.73	304.17	473.06	386.66	387.65	434.41	359.37	297.63	431.52	363.00
20-24 years	728.41	475.72	604.92	736.92	490.17	616.71	696.65	471.19	586.58	659.05	458.49	561.14	646.70	464.42	567.69
25 years and over	147.97	42.73	92.40	145.38	43.36	91.52	144.92	43.52	91.39	140.63	42.67	88.92	137.83	41.62	87.10
Chancroid															
All ages	0.03*	0.15	0.17	0.17	0.01*	0.09	0.19	0.02	0.10	0.20	0.02	0.11	0.19	0.03	0.11

* These rates were based on fewer than 10 events and consequently their reliability as a measure may be affected.

TABLEAU 111

Age-specific and Age-adjusted Gonorrhea Rates (per 100 000) for White Men and Woman in the United States (excluding New York and California) 1967 - 1979

Sex. Age (Years)		1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979
Men	≥ 50	1	1	1	2	2	2	3	3	3	3	3	3	4
	15-19	156	170	203	251	316	365	369	377	393	370	341	336	340
	20-24	553	638	703	780	901	1 004	1 007	1 028	1 060	1 007	955	922	909
	25-29	329	350	381	399	470	507	549	580	642	622	638	629	626
	30-39	118	128	133	145	163	174	183	198	229	238	251	250	255
	40-49	37	38	39	44	45	46	47	50	59	62	68	69	75
	40-49	13	13	13	14	14	15	14	17	18	19	20	20	21
	Total	94	106	121	141	173	197	206	220	240	239	238	237	240
	Unadjusted	94	106	121	141	173	197	206	220	240	239	238	237	240
	Age-adjusted	107	118	129	143	165	182	187	195	210	205	203	199	201
Women	≥ 50	3	4	4	5	8	10	12	12	14	13	13	14	14
	15-19	121	144	185	234	354	487	587	650	705	661	645	643	644
	20-24	178	202	237	295	383	542	686	757	802	744	723	692	692
	25-29	82	87	101	111	150	193	253	285	318	293	302	290	293
	30-39	27	31	31	36	46	62	76	79	88	88	86	82	83
	40-49	8	9	10	10	12	15	17	18	19	18	19	19	19
	40-49	3	3	3	3	4	4	5	6	6	6	5	5	5
	Total	38	44	54	67	95	131	164	184	201	191	189	185	186
	Unadjusted	38	44	54	67	95	131	164	184	201	191	189	185	186
	Age-adjusted	36	41	48	58	80	109	136	149	161	151	149	145	145

Age specific and Age-adjusted Gonorrhea Rates (per 100 000) for Nonwhite Men and Woman in the United States (excluding New York and California) 1967 - 1979

Sex. Age (Years)		1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979
Men	≥ 50	35	42	44	51	50	56	56	57	57	56	55	53	53
	15-19	4 223	4 551	5 121	5 295	5 322	5 559	5 724	5 772	5 687	5 326	4 958	4 711	4 446
	20-24	11 578	12 984	13 967	14 007	13 600	13 693	12 780	13 173	13 991	13 225	12 678	11 853	10 809
	25-29	7 430	7 570	7 877	7 760	7 825	8 012	8 184	8 651	9 073	8 487	8 487	8 154	7 543
	30-39	2 750	2 866	2 950	2 989	2 947	2 992	2 960	3 092	3 266	3 172	3 193	3 077	2 942
	40-49	810	817	834	835	813	816	804	836	894	888	870	886	832
	40-49	186	181	204	202	205	201	219	231	266	256	292	275	250
	Total	2 059	2 237	2 495	2 654	2 733	2 876	2 872	3 025	3 228	3 144	3 112	3 002	2 819
	Unadjusted	2 059	2 237	2 495	2 654	2 733	2 876	2 872	3 025	3 228	3 144	3 112	3 002	2 819
	Age-adjusted	2 385	2 549	2 714	2 728	2 695	2 742	2 695	2 794	2 926	2 776	2 715	2 587	2 404
Women	≥ 50	50	56	66	80	82	100	130	144	163	158	147	158	165
	15-19	1 852	2 090	2 414	2 608	2 948	3 854	5 161	5 683	5 980	6 084	6 024	6 268	6 099
	20-24	2 586	2 767	3 163	3 252	3 465	4 365	5 792	6 341	6 648	6 694	6 594	6 643	6 264
	25-29	1 351	1 318	1 526	1 532	1 597	2 040	2 589	2 698	2 954	2 799	2 808	2 874	2 756
	30-39	446	455	479	501	501	632	809	836	882	801	785	798	765
	40-49	113	112	100	106	113	133	161	190	187	185	158	159	154
	40-49	35	25	40	33	34	46	49	63	75	55	50	52	47
	Total	5 51	56	66	80	82	100	130	144	163	158	147	158	165
	Unadjusted	5 51	56	66	80	82	100	130	144	163	158	147	158	165
	Age-adjusted	2 385	2 549	2 714	2 728	2 695	2 742	2 695	2 794	2 926	2 776	2 715	2 587	2 404

Tiré de : Sexually Transmitted Diseases, vol. 10, no. 2, p. 73-74

sexuel, on pourrait conclure qu'il contribue à la propagation de la blennorragie plus que tout autre groupe d'âge tant chez les hommes que chez les femmes. Cependant, ces statistiques officielles ne nous permettent aucunement de savoir dans quelle mesure les différentes catégories "professionnelles" (dont les prostituées et les prostituées) contribuent à ce problème. Pour cette raison, nous abordons maintenant l'examen de certaines études qui ont tenté de répondre à cette question précise.

II. Incidence des MTS dans les autres pays occidentaux

L'incidence connue des MTS au Canada au cours des cinq dernières années nous révèle que les hommes âgés de 20 à 24 ans forment un groupe dont le risque de contamination est élevé. On pourrait alors conclure qu'ils sont responsables, plus que tout autre groupe établi en fonction de l'âge et du sexe, d'une grande partie des MTS. Cependant, puisque, au Canada, les MTS ne sont que partiellement déclarées et puisque les organismes qui les signalent sont habituellement fréquentes davantage par les hommes que par les femmes (8), il nous faut examiner les données en provenance d'autres pays occidentaux. Si on y retrouve les mêmes tendances, on pourra peut-être alors conclure qu'il y a une incidence plus élevée de certaines MTS chez les jeunes hommes et qu'en conséquence, ils contribuent à la transmission des MTS dans une proportion plus grande que tout autre groupe établi en fonction de l'âge et du sexe.

Le tableau suivant (tableau IV) nous fait voir qu'au Royaume-Uni, entre 1976 et 1980, les plus hauts taux de MTS signalées concernaient la blennorragie chez les hommes âgés de 20 à 24 ans. Ces taux se situaient entre 659 et 728 cas par 100 000 habitants. Les plus hauts taux de blennorragie chez les femmes se retrouvaient chez les groupes des 16-19 ans et des 20-24 ans. Ces taux se situaient autour de 500 cas par 100 000 habitants pour chacune des cinq années en question.

Les taux établis en fonction de l'âge et du sexe dans le cas de la blennorragie aux États-Unis nous permettent de constater une tendance semblable. Pendant la période allant de 1976 à 1979, on a également constaté les plus hauts taux de blennorragie chez les hommes (de race blanche et de couleur) âgés de 20 à 24 ans. De plus, ces taux sont sensiblement plus élevés que chez les femmes du même groupe d'âge.

Conclusion

Les données nous amènent à conclure que l'incidence de la blennorragie au Canada, au Royaume-Uni et aux États-Unis semble être la plus élevée chez les jeunes hommes âgés de 20 à 24 ans. Puisque ce groupe forme une grande partie de la population active sur le plan

- L'âge et le sexe sont des facteurs importants au niveau de la transmission des MTS. La blennorragie est diagnostiquée le plus souvent chez les jeunes hommes âgés de 20 à 24 ans. La plupart des MTS sont contractées par des hommes et des femmes dont l'âge varie de 15 à 30 ans,
- et les MTS chez les enfants, particulièrement chez les filles âgées de moins de 14 ans, ne constituent pas un phénomène rare.

avec l'Organisation mondiale de la santé. En 1982, on a signalé 1 724 cas d'infection par chlamydia au Canada. Selon le rapport de ce ministère, le nombre annuel réel de cas d'infection par chlamydia, dont les cas d'urétrite et de cervicite non gonococciques, est environ trois fois plus élevé que celui des cas de blennorragie (ministère de la Santé et du Bien-être social du Canada, 1983, p. 1).

Des 1 724 cas signalés, 68 % étaient des femmes et 29 % des hommes. On a signalé 82.9 % de tous les cas chez les 15-34 ans. Lorsque la partie de l'anatomie affectée était précisée, il s'agissait de l'appareil génital dans 75 % des cas (voir la figure 6).

Le syndrome d'immunoséquence acquise (SIDA) et la Neisseria gonorrhoeae produisant de la pénicilline (NGPP)

Bien que seulement un petit nombre de chacune de ces infections soit signalé annuellement, le nombre de cas de Neisseria gonorrhoeae produisant de la pénicilline (NGPP) est à la hausse au Canada. Depuis 1976, la Division des antimicrobiens et de microbiologie moléculaire du Laboratoire de lutte contre la maladie du ministère de la Santé et du Bien-être social du Canada a dénombré 175 cas d'isolement; de ce nombre, 41.7 % sont survenus en 1982. La plupart des NGPP ont été contractées à l'extérieur du pays, principalement en Asie.

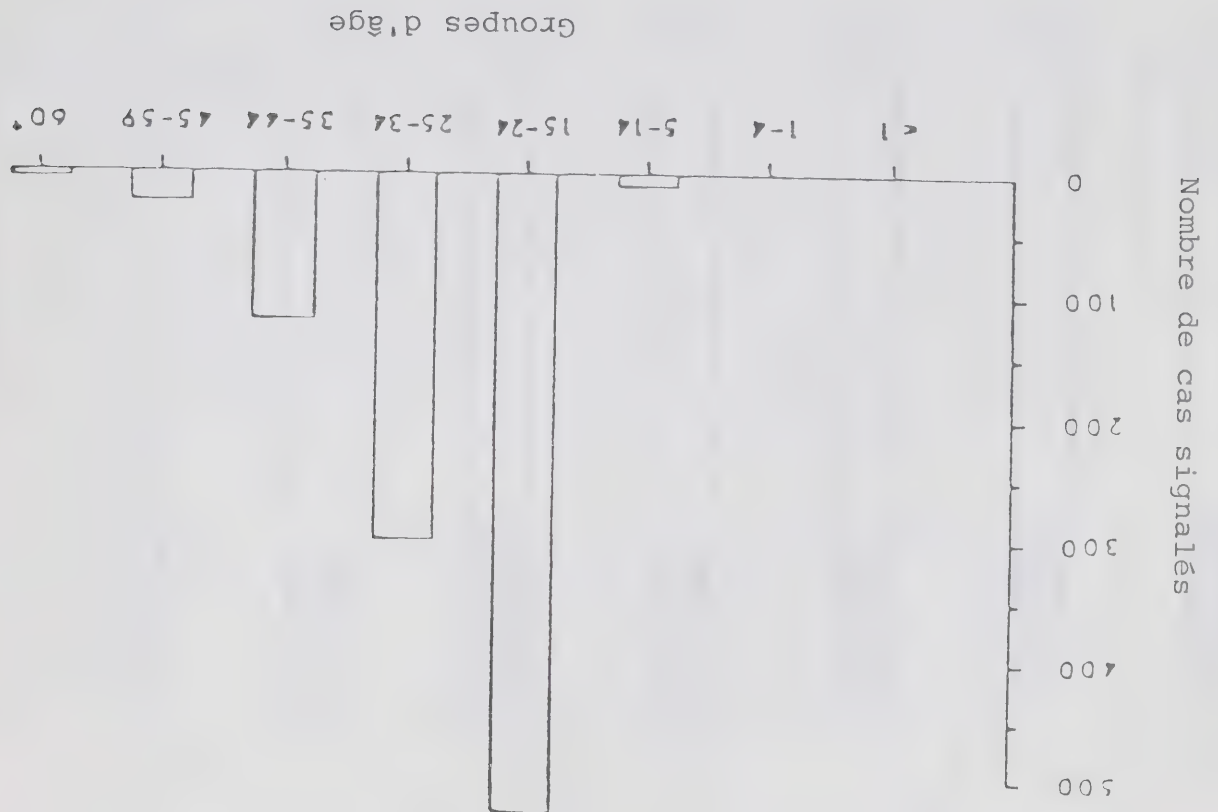
Au mois d'avril 1984, 74 cas de SIDA avaient été signalés au Laboratoire de lutte contre la maladie. Trente-neuf patients sont décédés, soit un taux de mortalité clinique de 52 %. Trente-sept patients étaient d'origine canadienne, vingt d'origine haïtienne et six étaient originaires d'autres pays. On a noté une orientation sexuelle de type homo et hétérosexuel dans quarante et un cas, et une orientation hétérosexuelle dans vingt-sept cas. La préférence n'a pu être obtenue, ou ne s'appliquait pas, dans les deux autres cas (un cas concernait un enfant d'origine haïtienne âgé de quatre mois).

Conclusions

Sans connaître le nombre réel de cas, on peut néanmoins formuler un certain nombre de conclusions au sujet des MTS au Canada. En effet, les données révèlent chaque année les mêmes tendances. Ces conclusions sont les suivantes :

CAS D'INFECTION DE L'APPAREIL GÉNITAL PAR CHLAMYDIA
 Nombre de cas signalés selon certains groupes d'âge
 Laboratoires de virologie canadiens, 1982

Figure 6

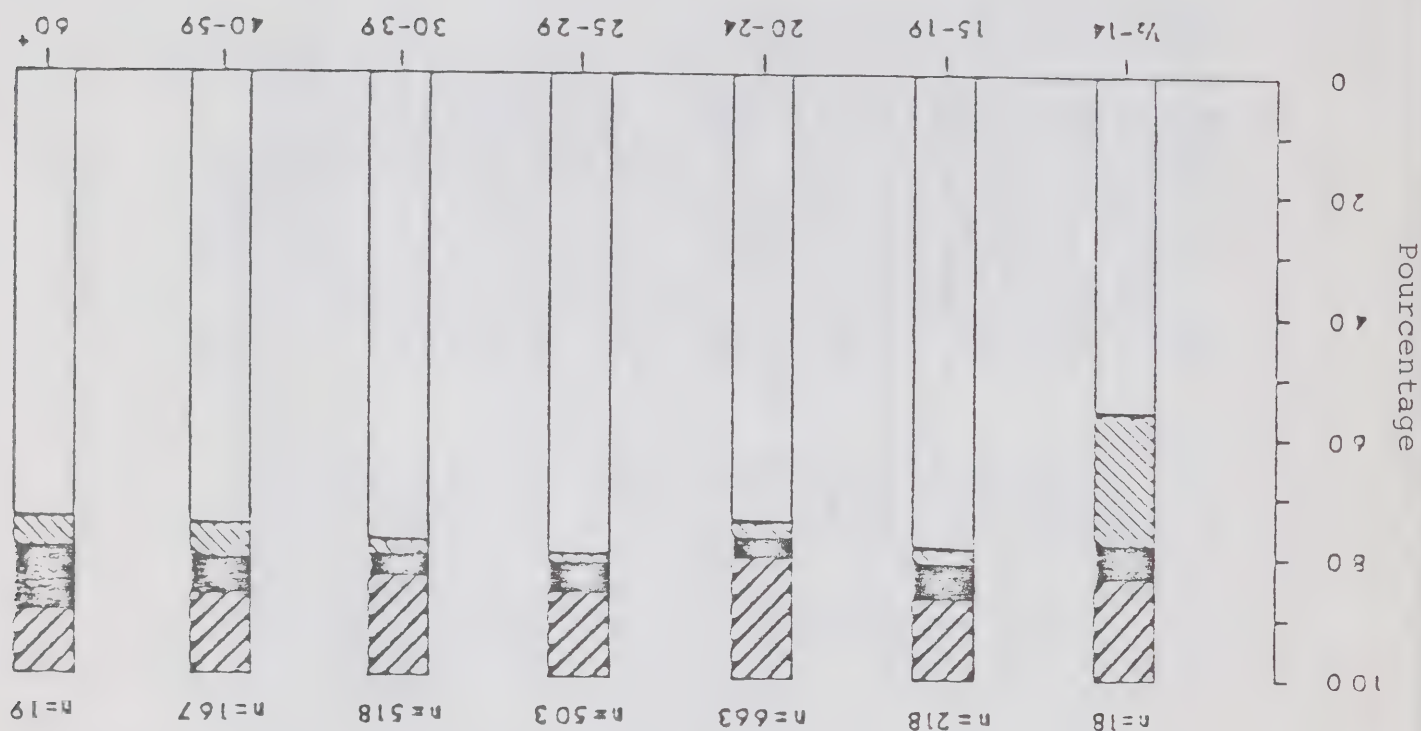


Tiré de Maladies transmises sexuellement au Canada en 1982

CAS SIGNALÉS D'HERPÈS DU TRACTUS GÉNITAL
 Pourcentage par groupes d'âge et types viraux
 Laboratoires de virologie canadiens, 1982

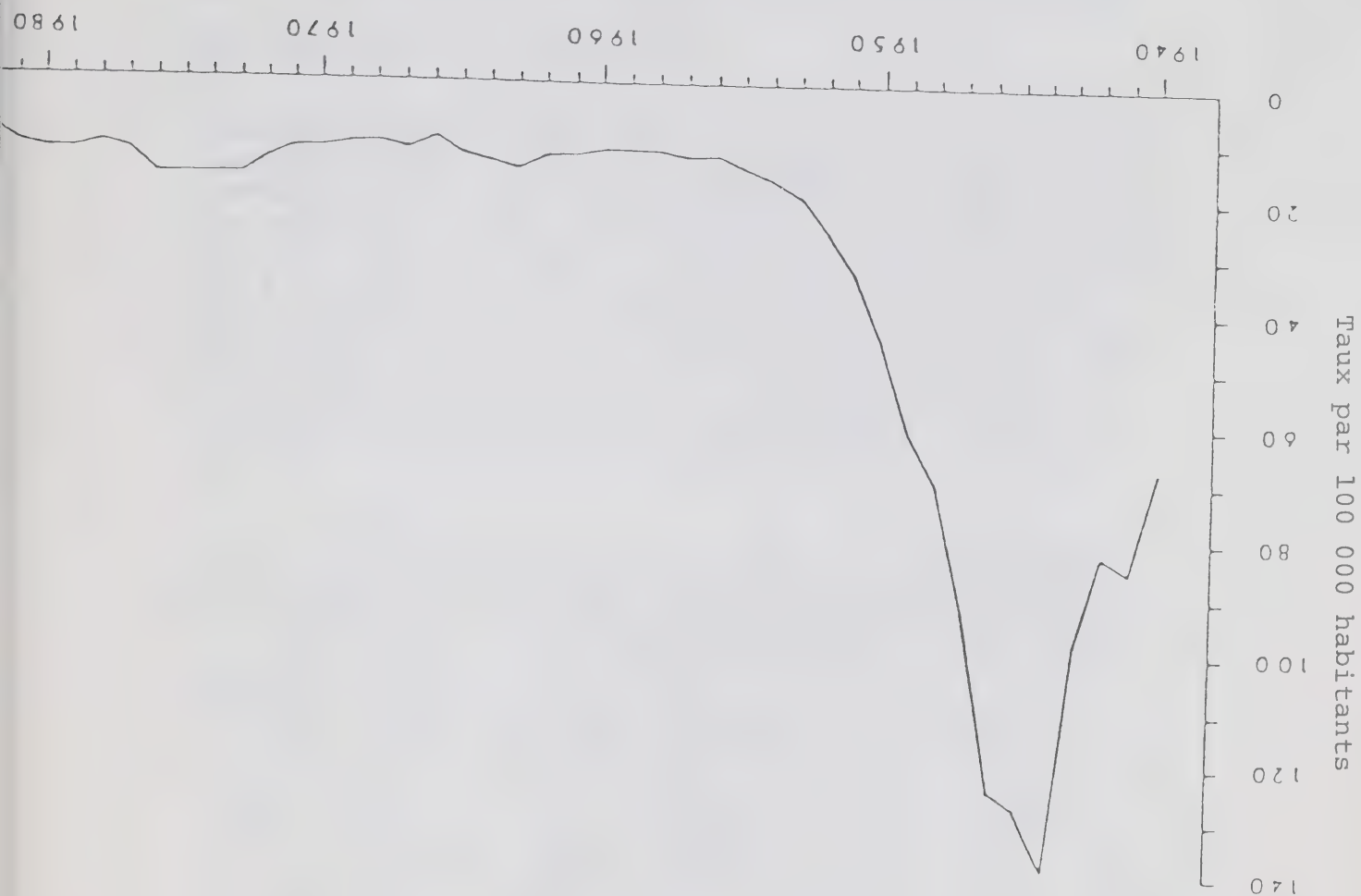
Figure 5

- Herpèsvirus non type
 - Herpèsvirus de type 1
 - Herpèsvirus de type 2



Tiré de Maladies transmises sexuellement au Canada 1982

Tiré de Maladies transmises sexuellement au Canada 1982



TOTAL DES CAS DE SYPHILIS, CANADA, 1940-1982
Taux par 100 000 habitants par an

Figure 4

diminué vers la fin des années 1940 et n'ont pas augmenté depuis ce temps (voir la figure 4). Tout comme la blennorragie, la syphilis est une maladie que l'on rencontre le plus souvent chez les jeunes gens et, plus particulièrement, chez les jeunes hommes; en 1982, 62 % de tous les cas de syphilis infectieuse ont été signalés chez les hommes âgés de 25 à 39 ans. L'incidence de cette infection est beaucoup plus élevée chez les hommes que chez les femmes en raison, semble-t-il, de la syphilis contractée par des rapports homosexuels (ministère de la Santé et du Bien-être social du Canada, 1983, p. 18).

L'herpès

L'herpès, connu au sein de la profession médicale sous le nom d'"infection par herpèsvirus simplex", provoque non seulement des lésions cutanées mais également une infection génitale. La découverte de deux variantes antigéniques*, l'herpèsvirus de type 1 et celui de type 2, a permis de préciser l'épidémiologie* de cette maladie. Dans la majorité des cas, l'herpèsvirus de type 1 cause des lésions dans les parties du corps situées au-dessus de la taille alors que l'herpèsvirus de type 2 cause des lésions au-dessous de la taille. Contrairement à la blennorragie, l'herpès ne peut être guéri, bien qu'on puisse en réduire les effets par l'emploi de médicaments et un soutien psychologique (voir la figure 5).

Bien que l'herpès ne soit pas une maladie à déclaration obligatoire, 22 laboratoires canadiens qui collaborent avec l'Organisation mondiale de la santé ont signalé 6 224 cas d'infection par herpèsvirus au Laboratoire de lutte contre la maladie, d'Ottawa, en 1982. Parmi les cas d'herpès ou la variante antigénique a été indiquée, 219 cas d'herpèsvirus de type 2 (lésions au-dessous de la taille) ont été signalés chez les hommes (3.5 % des cas signalés) et 262 chez les femmes (4.2 %). Les personnes du groupe d'âge de 20-24 ans étaient plus fréquemment touchées (22.3 %), venaient ensuite les groupes des 30-39 ans (17.3 %) et des 25-29 ans (16.4 %).

Les infections par chlamydia

Ces infections sont signalées au Bureau de microbiologie du ministère de la Santé et du Bien-être social du Canada par 32 laboratoires qui collaborent

* Voir la partie intitulée "Définitions et annotations" pour une explication de ce terme.

TABLEAU II

TOTAL DES CAS DE BLENNORRAGIE PAR ÂGE ET SEXE
CANADA, 1982

ÂGE	HOMMES		FEMMES		TOTAL ¹	
	CAS	Taux	CAS	Taux	CAS	Taux
< 1	7	3.7	9	5.0	16	4.4
1-4	3	0.4	22	3.1	25	1.7
5-9	1	0.1	32	3.7	33	1.9
10-14	46	4.7	211	22.9	257	13.6
15-19	4 063	353.8	6 563	598.8	10 626	473.4
20-24	11 239	946.4	7 816	663.3	19 058	805.5
25-29	7 310	657.0	3 363	299.5	10 675	477.5
30-39	6 399	335.9	1 899	100.4	8 298	218.6
40-59	2 169	85.8	422	16.6	2 591	51.1
60+	147	9.7	21	1.1	168	4.9
TOTAL*	32 081	262.8	20 894	168.1	53 076	215.4

Note : Taux par 100 000 habitants.
1. Comprend des cas pour lesquels le sexe n'est pas précisé.
* Comprend des cas pour lesquels le sexe ou l'âge ne sont pas précisés.

Tiré de Maladies transmises sexuellement au Canada 1982



TOTAL DES CAS DE BLENNORRAGIE, CANADA, 1940-1982 -
Taux par 100 000 habitants par an

Figure 3

nous estimons qu'il y a eu presque 1 000 cas en 1982. Bien que certains cas impliquent des nouveaux-nés qui attrapent la maladie au moment de l'accouchement, le ministère de la Santé et du Bien-être social du Canada (1983, 1984) affirme que la blennorragie infantile devrait être considérée comme étant un indice de mauvais traitements d'ordre sexuel.

"... on croit que l'abus sexuel est responsable de la plupart des cas de blennorragie qui se déclarent pendant l'enfance. Très peu de données sont compilées au Canada sur la fréquence de l'abus sexuel des enfants; tout diagnostic de maladie vénérienne chez des enfants - entre 1 an et l'âge de la puberté - devrait toutefois, jusqu'à preuve du contraire, être considéré comme un indicateur de ce problème." (Santé et Bien-être social Canada, 1984, p. 50)

Suzanne Sgroi (1982) adopte une position semblable. Elle affirme qu'à l'exception des infections néonatales et des infections gonococciques des yeux, il existe bien peu de preuves permettant de croire que la blennorragie peut être transmise autrement que par voie sexuelle, et ce, à l'égard de tous les groupes d'âge.

La syphilis

Le mot "syphilis" tire ses origines d'un poème écrit par Frascatorî en 1530. Le poème décrit un gardien de porcs, nommé Syphilus, qui a contracté la maladie. Cette infection est d'une grande chronicité et peut s'attaquer à toutes les parties du corps. En 1910, en Angleterre et au pays de Galles, le greffier général a enregistré 1 639 décès causés chez les adultes par cette maladie et 1 200 chez les enfants. De plus, on considère que ces chiffres ont été largement sous-estimés puisque, dans un grand nombre de cas, on a pu établir avec certitude que le décès avait été causé par la syphilis. Sir William Osler, professeur de médecine à l'Université d'Oxford, a évalué qu'en 1917 le nombre de décès causés par la syphilis chez les adultes se chiffrait vraisemblablement à 60 000 alors que les chiffres officiels en indiquaient moins de 2 000 (Adler, 1980, p. 206). Aujourd'hui, grâce à la médecine moderne, la syphilis n'entraîne pas de conséquences physiques importantes chez plus de 50 % des personnes atteintes.

Au Canada, les cas déclarés de syphilis ont augmenté brusquement pendant la période de la guerre, ont

La blennorragie

La blennorragie est une très ancienne maladie; elle était connue des premiers Chinois, du temps de l'empereur Huang-ti, en l'an 2637 av. J.-C. Chez les hommes, la blennorragie est habituellement symptomatique, et les symptômes apparaissent moins d'une semaine après que l'infection a été contractée. Par contre, les femmes ne savent souvent pas qu'elles souffrent de cette infection. Puisque les symptômes sont souvent peu importants, environ 20 % des femmes se doutent qu'elles ont la maladie alors que 80 % n'ont absolument aucun symptôme (6).

La figure 3 nous fait voir que l'incidence de la blennorragie au Canada a augmenté pendant la Seconde Guerre mondiale pour brusquement diminuer pendant les années 1950. Au début des années 1970, l'incidence a recommencé à augmenter. La blennorragie possède la plus haute incidence rapportée de toutes les MTS à déclaration obligatoire au Canada, avec 95.9 % de l'ensemble des cas. Elle est suivie par la syphilis (4 %) alors que toutes les autres ne représentent que 0.1 %.

Le nombre de cas rapportés est le plus élevé chez les jeunes hommes âgés de 20 à 24 ans (946.4 cas par 100 000 habitants en 1982). Viennent ensuite le groupe formé des femmes du même âge (663.3) et celui des hommes âgés de 25 à 29 ans (657.0) (7).

Il est renversant de constater le nombre de cas de blennorragie déclarés chez les enfants (voir le tableau II). Trois cent trente et un cas ont été déclarés en 1982 chez les enfants âgés de moins de 14 ans. Quatre-vingt-trois pour cent de ces cas ont été signalés chez des filles. Le ministère de la Santé et du Bien-être social du Canada croit que ces chiffres seraient bien plus élevés si ce n'était du fait que plusieurs cas ne sont pas déclarés (Santé et Bien-être social Canada, 1984, p. 51). En adoptant la règle approximative que nous avons utilisée précédemment afin d'évaluer l'incidence "réelle" de la blennorragie,

6. Tiré d'une entrevue avec le Dr Jessamine.

7. Au cours des cinq dernières années, les hommes âgés de 20 à 24 ans ont eu un taux de blennorragie beaucoup plus élevé (d'environ 30 %) que n'importe quel autre groupe. Le nombre de cas a varié de 871 à 1 021 par 100 000 habitants.

facteurs, c'est-à-dire l'absence de déclaration et le petit nombre de maladies qui doivent être déclarées, l'incidence réelle des maladies transmises sexuellement au Canada est donc beaucoup plus élevée que nos statistiques nationales ne l'indiquent.

Le tableau suivant mesure l'incidence réelle de ces maladies.

TABLEAU 1 : L'incidence des MTS au Canada en 1982

Cas déclarés* Estimation du nombre réel de cas **		
Urétrite et cervicite non gonococciques -	-	477 900
Blennorragie	53 100	159 300
Syphilis	1 000	1 100
Condylome	-	159 300
Herpès (d'origine génitale seulement)	2 600	31 900
Total	56 700	829 500

(Tous les chiffres ont été arrondis au multiple de cent le plus rapproché)
 * Tiré de : Maladies transmises sexuellement au Canada 1982

** Ces chiffres ont été obtenus à partir de l'estimation de l'incidence réelle de chacune de ces maladies, telle qu'elle est exposée à la page 1 du rapport intitulé Maladies transmises sexuellement au Canada 1982, et à partir de renseignements fournis par le Dr Jessamine, le Dr Hockin et Marion Todd, du Laboratoire de lutte contre la maladie, ministère de la Santé et du Bien-être social du Canada.

Puisque chaque MTS possède des caractéristiques différentes et un taux d'incidence unique, nous les analyserons séparément dans la présente section.

provinces, qui les font parvenir à Statistique Canada. Le rapport présenté par ce ministère en 1983, intitulé Maladies transmises sexuellement au Canada 1982, comprenait des renseignements sur la blennorragie, la syphilis, la syphilis infectieuse, la syphilis latente, le syndrome d'immunodéficience acquise (SIDA), les infections par herpèsvirus et les infections par chlamydia. Cependant, on sous-estime l'ampleur du problème des MTS au Canada en raison de deux facteurs : le non-respect du système de déclaration et le petit nombre des MTS qui doivent être déclarées (seules les maladies vénériennes "classiques" doivent être déclarées).

Au Canada, le système national de déclaration ne s'applique pas à certaines infections transmises sexuellement, telles que les infections génitales non gonococciques, les trichomonas et les condylomes, qui, selon ce rapport, sont au moins aussi fréquentes que la blennorragie.

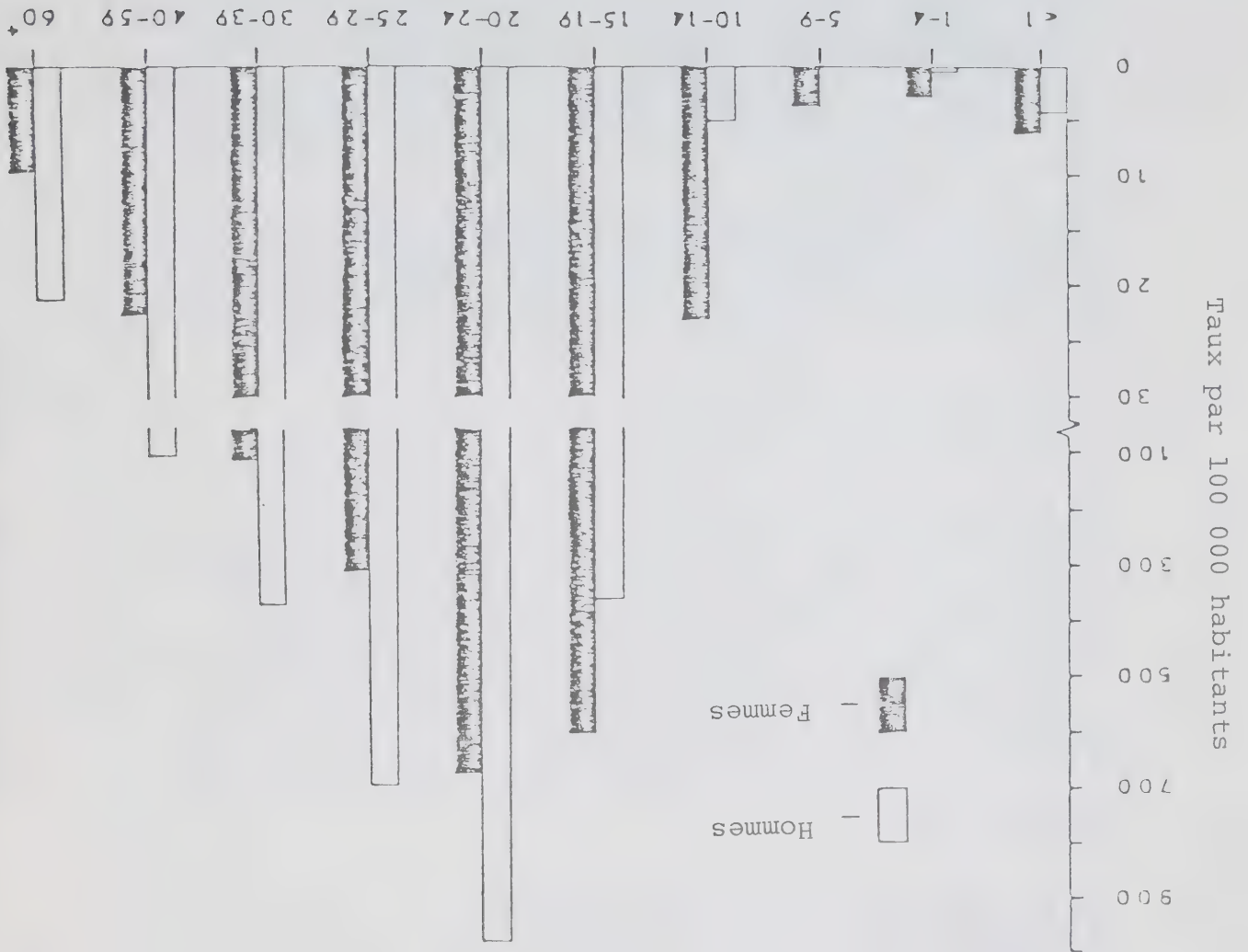
"On estime qu'il y a trois cas d'urétrite et de cervicite non gonococciques pour chaque cas de blennorragie, un cas d'herpès pour cinq cas de blennorragie et que les condylomes sont diagnostiqués aussi fréquemment que la blennorragie dans les cabinets privés et les cliniques pour maladies vénériennes." (Ministère de la Santé et du Bien-être social du Canada, 1983, p. 1)

On croit qu'environ un tiers de tous les cas de blennorragie et environ 90 % de tous les cas de syphilis sont déclarés aux gouvernements provinciaux (4). Il est plus probable qu'un cas soit déclaré s'il a été diagnostiqué dans une clinique antivenérienne qui est subventionnée par des fonds publics, que s'il l'a été dans un service de santé pour étudiants, un hôpital ou un cabinet privé (5) (Les médecins qui pratiquent dans des cabinets privés sont habituellement ceux qui déclarent le moins de cas.) En raison de ces deux

4. Tiré d'une entrevue avec le Dr Jessamine, Marion Todd et le Dr Hockin, du Laboratoire de lutte contre la maladie, ministère de la Santé et du Bien-être social du Canada.

5. Ibid.

Groupes d'âge



TOTAL DES CAS DE MALADIES TRANSMISES SEXUELLEMENT
(MTS) À DÉCLARATION OBLIGATOIRE, CANADA, 1982
- Taux par 100 000 habitants, par groupes d'âge et sexe

Figure 2

TOTAL DES CAS DE MALADIES TRANSMISES SEXUELLEMENT
(MTS) À DÉCLARATION OBLIGATOIRE, CANADA, 1971-1982
- Taux par 100 000 habitants, par an

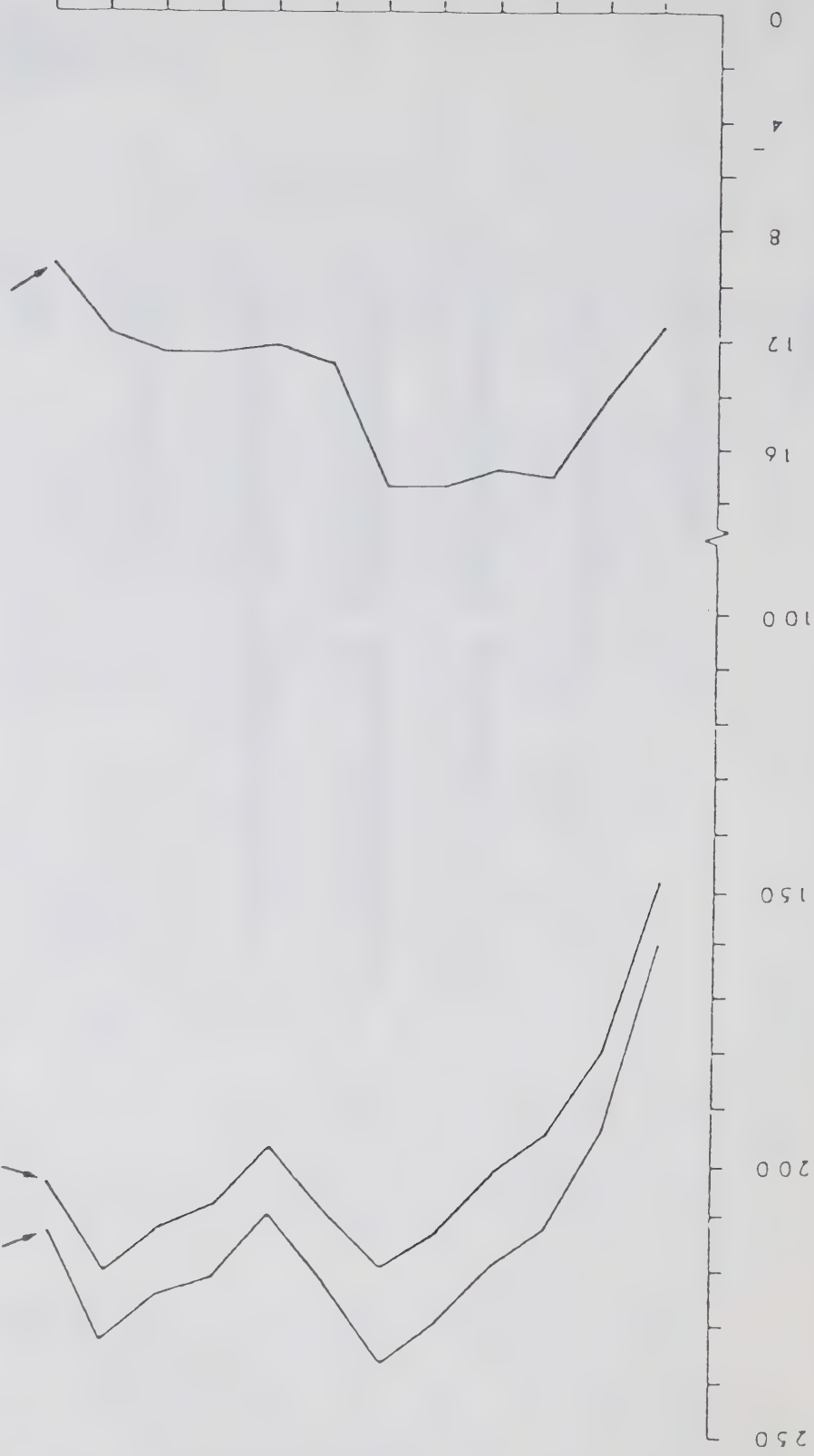
MTS (total)
Infections
gonococciques
(total)

Syphilis
(Total)

Tiré de Maladies
transmises sexuel-
lement au Canada
1982

1971 72 73 74 75 76 77 78 79 80 81 82

Taux par 100 000 habitants



que la promiscuité sexuelle pose davantage un problème. Bien que le document ne puisse déterminer une fois pour toutes dans quelle mesure les prostituées et les prostituées contribuent à la propagation des maladies vénériennes au Canada (vu l'absence de données susceptibles de pouvoir prouver cette affirmation), on peut néanmoins tenter de répondre à cette question pour les autres pays occidentaux où de telles études ont été effectuées.

S'il est établi que la prostitution contribue de façon significative à la propagation des MTS, on pourra alors soutenir qu'il est nécessaire d'adopter des mesures spéciales afin d'enrayer ce problème. Dans le but de répondre aux questions des politiciens concernant les mesures de contrôle, le présent document fait une description et une évaluation de l'efficacité des méthodes utilisées par les prostituées et les prostituées pour restreindre la propagation des MTS.

Méthodologie

Pour l'étude de ces questions, nous avons passé en revue la littérature sur la prostitution et les maladies transmises sexuellement. À notre connaissance, aucun travail empirique n'a été fait au Canada concernant le lien qui pourrait exister entre la prostitution et la propagation des MTS. La plupart des études sont américaines ou encore britanniques. Cependant, au Canada comme dans la majorité des pays occidentaux, on recueille des données sur l'incidence de certaines MTS et des complications qu'elles entraînent.

1. INCIDENCE DES MTS AU CANADA

Le ministère de la Santé et du Bien-être social du Canada publie annuellement des données sur l'incidence, à l'échelle nationale, des maladies transmises sexuellement (c.-à-d. le nombre de nouveaux cas chaque année) (3). Ces données sont recueillies par les

3. Noter la différence qui existe entre "incidence" et "prévalence". Voir à ce sujet la partie intitulée "Définitions et annotations". Toutes les statistiques et les informations exposées dans la présente partie relativement aux MTS au Canada proviennent du rapport du ministère de la Santé et du Bien-être social du Canada intitulé Maladies transmises sexuellement au Canada 1982.

TOTAL DES CAS DE MALADIES TRANSMISES SEXUELLEMENT
(MTS) À DÉCLARATION OBLIGATOIRE, CANADA, 1971-1982
- Taux par 100 000 habitants, par an

MTS (total)
Infections
gonococciques
(total)

Syphilis
(Total)

Tiré de Maladies
transmissibles sexuel-
lement au Canada
1982

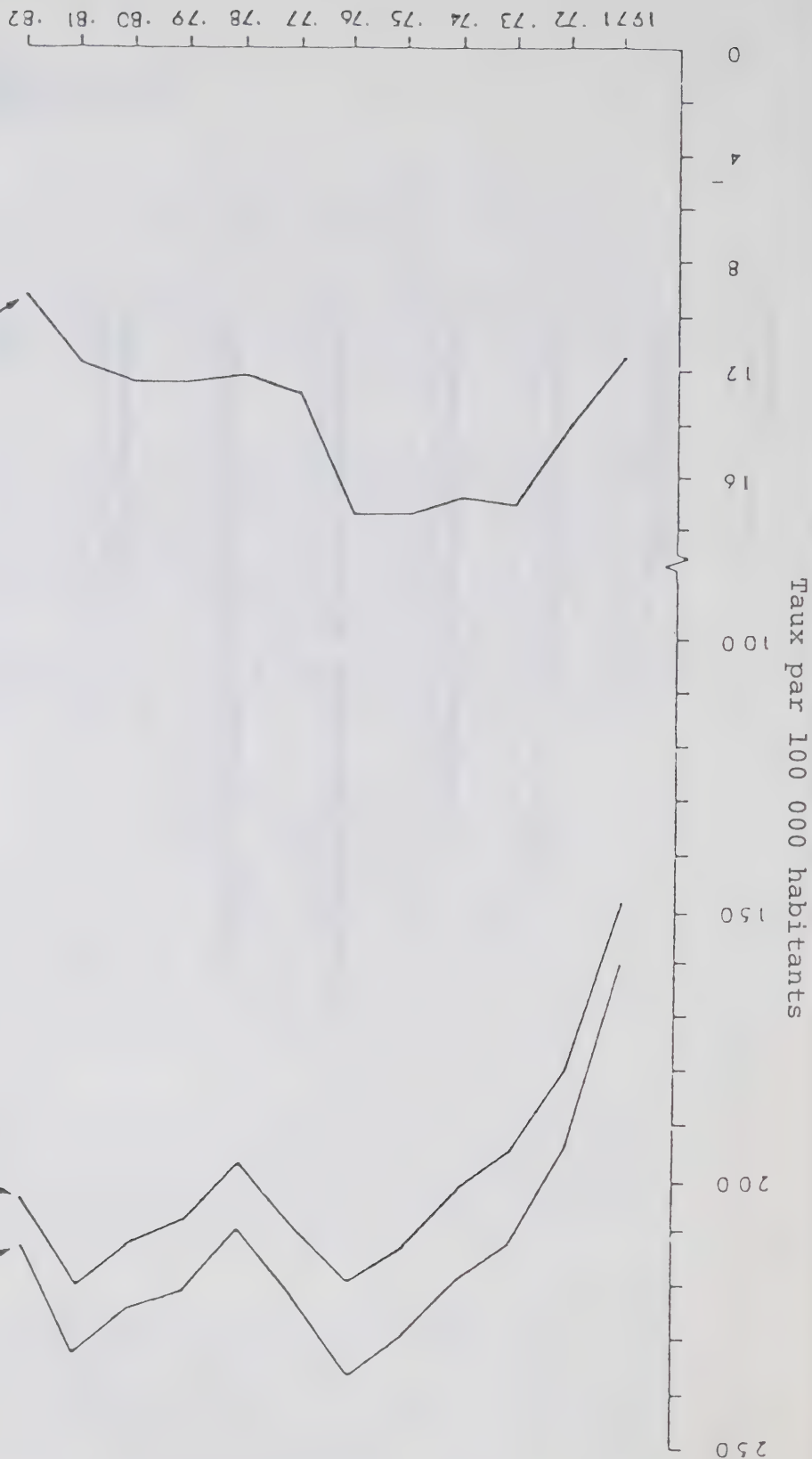


Figure 1

que la promiscuité sexuelle pose davantage un problème. Bien que le document ne puisse déterminer une fois pour toutes dans quelle mesure les prostituées et les prostituées contribuent à la propagation des maladies vénériennes au Canada (vu l'absence de données susceptibles de pouvoir prouver cette affirmation), on peut néanmoins tenter de répondre à cette question pour les autres pays occidentaux où de telles études ont été effectuées.

S'il est établi que la prostitution contribue de façon significative à la propagation des MTS, on pourra alors soutenir qu'il est nécessaire d'adopter des mesures spéciales afin d'enrayer ce problème. Dans le but de répondre aux questions des politiciens concernant les mesures de contrôle, le présent document fait une description et une évaluation de l'efficacité des méthodes utilisées par les prostituées et les prostituées pour restreindre la propagation des MTS.

Méthodologie

Pour l'étude de ces questions, nous avons passé en revue la littérature sur la prostitution et les maladies transmises sexuellement. À notre connaissance, aucun travail empirique n'a été fait au Canada concernant le lien qui pourrait exister entre la prostitution et la propagation des MTS. La plupart des études sont américaines ou encore britanniques. Cependant, au Canada comme dans la majorité des pays occidentaux, on recueille des données sur l'incidence de certaines MTS et des complications qu'elles entraînent.

1. INCIDENCE DES MTS AU CANADA

Le ministère de la Santé et du Bien-être social du Canada publie annuellement des données sur l'incidence, à l'échelle nationale, des maladies transmises sexuellement (c.-à-d. le nombre de nouveaux cas chaque année) (3). Ces données sont recueillies par les

3. Noter la différence qui existe entre "incidence" et "prévalence". Voir à ce sujet la partie intitulée "Définitions et annotations". Toutes les statistiques et les informations exposées dans la présente partie relativement aux MTS au Canada proviennent du rapport du ministère de la Santé et du Bien-être social du Canada intitulé Maladies transmises sexuellement au Canada 1982.

Introduction

Le présent document a pour but d'examiner si la prostitution contribue de façon significative à la propagation des maladies transmises sexuellement (MTS) et de déterminer quelles sont, parmi les mesures prises par les prostituées et les prostituées afin d'empêcher la propagation de ces maladies, celles qui ont été efficaces par le passé (1).

Les MTS peuvent causer des torts considérables (2). Elles peuvent entraîner de graves problèmes de santé tant pour les prostituées et les prostituées que pour leurs clients. Des complications telles que le syndrome inflammatoire pelvien, les grossesses extra-utérines et l'infertilité involontaire imposent à la société un fardeau humain et financier considérable. À lui seul, le syndrome inflammatoire pelvien coûte environ \$ 28 millions à l'économie canadienne chaque année : \$ 400 000 pour les consultations médicales, \$ 22.6 millions pour les interventions chirurgicales et \$ 5 millions pour les heures de travail perdues (Romanowski, 1983, p. 153). Vers la fin des années 1970, les cas peu compliqués de MTS et leurs suites ont coûté plus de \$ 200 millions annuellement à l'économie canadienne (Jessamine et autres, 1983, p. 164). Toutefois, ces chiffres ne tiennent nullement compte du coût social et personnel des MTS.

Le présent document examine le rapport qui existe entre les maladies transmises sexuellement et la prostitution. En effet, certaines personnes prétendent que la prostitution contribue de façon significative à la propagation des MTS, alors que d'autres affirment

1. Voir la partie intitulée "Définitions et annotations" pour un aperçu des différentes infections qui sont habituellement regroupées sous le nom de "maladies transmises sexuellement".

2. Les maladies vénériennes contractées de façon volontaire constituent un phénomène reconnu. Les prostituées anglaises qui offraient leurs "services" aux membres du corps expéditionnaire britannique qui servaient en France durant la Première Guerre mondiale exigeaient un prix plus élevé lorsqu'elles se savaient malades, parce que le fait d'être atteint d'une maladie vénérienne permettait aux soldats de quitter les tranchées (Adler, 1980, p. 208).

TABLE DES MATIERES

Résumé

Page

1

Introduction

2

Méthodologie

2

I. Incidence des MTS au Canada

• Blennorragie

• Syphilis

• Herpès

• Infections par chlamydia

• SIDA et NGP

• Conclusions

10

II. Incidence des MTS dans les autres pays

occidentaux

• Conclusion

12

III. Prostitution et MTS : recherches effectuées aux
Etats-Unis et au Royaume-Uni

• Conclusions

20

IV. Lutte contre les MTS chez les personnes

se livrant à la prostitution

• Conclusions

21

Définitions et annotations

Bibliographie

Annexe I : Textes nationaux et

internationaux relatifs

aux maladies vénériennes

Annexe II : Etude sur les cliniques

antivénériennes au

Canada

inefficace pour empêcher la propagation des MTS, mais qu'elle soulève également de sérieuses questions concernant la morale et les droits de la personne. Les mesures de contrôle les plus efficaces résident dans l'éducation du public et l'existence de services de santé spécialisés et faciles d'accès.

Par conséquent, la question n'est pas de savoir si les prostituées et les prostituées contribuent de façon significative aux MTS mais plutôt de déterminer ce qui devrait ou pourrait être fait relativement à ce problème social grandissant. Nous en arrivons donc à la conclusion qu'au Canada, ce problème peut être abordé ainsi :

- procéder à des recherches multidisciplinaires, qui ne font pas de distinction à l'endroit des femmes, afin de déterminer quelles sont les mesures d'ordre médical et social qui sont efficaces pour réduire la prévalence des MTS;

- porter une grande attention au problème de l'inceste et à ses liens avec les MTS rencontrées chez les enfants canadiens;

- éduquer le public canadien, les personnes atteintes de MTS, le personnel oeuvrant dans le domaine de la santé et du bien-être social, les groupes chez qui le risque de contamination est élevé, et les politiciens à propos des MTS et des mesures de prévention.

Résumé

Le présent document a pour but de déterminer si les personnes se livrant à la prostitution contribuent de façon significative à la propagation des maladies transmissibles sexuellement (MTS) et d'identifier quelles sont les mesures les plus efficaces pour régler le problème.

L'étude en arrive à la conclusion que les prostituées ne contribuent pas de façon significative à la propagation des MTS. En effet, bien que l'incidence de la blennorragie soit plus élevée chez les prostituées* que chez les autres femmes à qui on les a comparées, quatre cas de blennorragie sur cinq rencontrés au Royaume-Uni (Turner et Morton, 1976) pouvaient l'être chez les femmes qui n'étaient pas des prostituées. En 1983, le Dr Neumann (1983, p. 155) en est arrivé à la conclusion que cette proportion avait diminué et que les prostituées contribuaient maintenant à moins d'un cas sur dix.

Cette conclusion s'appuie sur le bon sens. En effet les prostituées ne représentent plus maintenant qu'un très faible pourcentage de la population active sur le plan sexuel, elles pratiquent fréquemment l'amour oral, qui provoque rarement la contamination du client*, et la plupart d'entre elles utilisent régulièrement des prophylactiques. Par conséquent, les prostituées ne sont pas des contaminants importants bien qu'elles soient atteintes de MTS plus souvent qu'une personne moyenne.

Le bon sens nous amène également à conclure que ce sont peut-être les jeunes hommes âgés de 20 à 24 ans qui contribuent de façon la plus significative à la propagation des MTS. Au Royaume-Uni, au Canada et aux États-Unis, la blennorragie est diagnostiquée plus fréquemment chez ce groupe que chez tout autre groupe d'âge formé d'hommes et de femmes. De plus, ce groupe représente une partie importante de la population active sur le plan sexuel, et dont les membres ne sont pas particulièrement bien informés des mesures de prévention et de traitement des MTS.

En portant notre attention sur la prostitution, nous tentons de trouver une solution facile à un problème complexe. Il n'est pas étonnant que les travaux de recherche et le bon sens nous montrent que cette approche est non seulement

- * La plupart des études ne tiennent pas compte des prostituées.
- ** Tiré d'une entrevue avec le Dr Jessamine.

Remerciements

Nous désirons remercier toutes les personnes qui ont participé à la rédaction de ce document et particulièrement le Dr Jessamine, Marion Todd et le Dr Hockin, du Laboratoire de lutte contre la maladie du ministère de la Santé et du Bien-être social du Canada, pour leurs conseils judicieux, Sue Higgins pour son aide inestimable au niveau de la documentation, Daniel Sanstagon pour sa patience sans limites et ses observations pertinentes, Bernard Starkman, Patricia Bégin et Yvon Dandurand pour leurs précieux conseils, ainsi que tous ceux sans lesquels le présent document n'aurait pas de raison d'être.

PROSTITUTION ET PROPAGATION
DES MALADIES TRANSMISES SEXUELLEMENT

Margot Haug
Maltaise Cini

Mai 1984

Les opinions exprimées dans
le présent rapport sont
celles des auteurs et ne
sont pas nécessairement
partagées par le ministère
de la Justice.

